DOCUMENT RESUME

ED 308 000 PS 018 068

AUTHOR Mack, Sarah L.
TITLE Increasing Preventive Health Care in Young Children through Parental Involvement.
PUB DATE 89
NOTE 132p.; Ed.D. Practicum, Nova University.
PUB TYPE Dissertations/Theses - Practicum Papers (043)

EDRS PRICE MF01/PC06 Plus Postage.
DESCRIPTORS Agency Cooperation; *Comprehension; *Disadvantaged Youth; Family Health; *Health Needs; *Health Services; Intervention; Low Income Groups; *Parent Participation; Preschool Children; Preschool Education; *Prevention; Workshops
IDENTIFIERS Child Health; *Child Health Care

ABSTRACT

A health specialist serving a child care program in a metropolitan ghetto implemented a practicum to increase parent involvement with the health needs of their children. Goals were to: (1) ensure preventive and follow-up health care of children by increasing parents' use of medical resources; and (2) provide continuous education to parents in pediatric preventive health care and therapeutic practices. To attain these goals, a 12-week program for 100 parents (mothers) of preschool children was implemented. Three workshops covered comprehensive and preventive health care for children. Surveys tracked parents' inhibitions and unease toward community clinics. A system of communication was established between the centers and clinics. Practicum evaluation data indicated that all parents met the educational objectives. Aided by extensive reinforcement and cooperation by centers and clinics, 96 of 100 parents kept their children's ongoing appointments. It is concluded that when parents are provided the opportunity, they can learn preventive and curative well-child health concepts. If the atmosphere for learning is a nurturing environment with parents and providers sharing equal partnership in children's health, parents will assume responsibility. Related materials are appended. (RH)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED308000

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
This document has been reproduced as received from the person or organization originating it.
X Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Increasing Preventive Health Care in Young Children through Parental Involvement

by

Sarah L. Mack

Cluster 28

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Sarah L. Mack
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

PS 018038

A Practicum I Presented to the
Ed.D. Program in Early and Middle Childhood
in Partial Fulfillment of the Requirements
for the Degree of Doctor of Education.

NOVA UNIVERSITY

1989

BEST COPY AVAILABLE

PRACTICUM APPROVAL SHEET

This practicum took place as described.

Verifier: Dr. W. Allen Scheaf
Dr. W. Allen Scheaf

Psychologist (Private Practice)
Title

10900 Carnegie Avenue, Suite #306
Address

Cleveland, Ohio 44106
City State Zip

October 4, 1988
Date

This practicum report was submitted by Sarah L. Mack under the direction of the adviser listed below. It was submitted to the Ed.D. Program in Early and Middle Childhood and approved in the partial fulfillment of the requirements for the degree of Doctor of Education at Nova University.

Approved:

Date of Final Approval of Report

Georgianna Lowen (signature)
Ed.D., Adviser

TABLE OF CONTENTS

Page

TABLE OF CONTENTS iii

LIST OF TABLES v

ABSTRACT. vi

Chapter

I INTRODUCTION 1

Description of Community 1
Writer's Work Setting and Role 4

II STUDY OF THE PROBLEM 8

Problem Description. 8
Problem Documentation. 11
Causative Analysis 12
Relationship of the Problem to the Literature. 17

III ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS. 32

Goals and Expectations 32
Behavioral Objectives. 32
Measurement of Objectives. 33
Mechanism for Recording Unexpected Events. 36

IV SOLUTION STRATEGY. 37

Discussion and Evaluation of Solutions 37
Description of Selected Solution 43
Report of Action Taken 46

V RESULTS, CONCLUSIONS, AND RECOMMENDATIONS. 51

Results. 51
Conclusions. 65
Recommendations. 73
Dissemination. 73

REFERENCES 75

Appendices

A CONTRACT FOR DENTAL SERVICES 78

B WRITTEN LETTERS FROM STAFF AND PROVIDER. 86

C PRE- AND POST-ATTITUDE TEST. 94

D LIST OF MEDICAL SCREENINGS IN ANNUAL PEDIATRIC EXAMINATION - EXPLANATION OF MEDICAL SCREENINGS AND RESULTS - FOLLOW-UP PROCEDURES 96

E WRITTEN ACTIVITY - SCREENINGS REMEMBERED 101

F ORAL ACTIVITY - INTERPRETATION AND MEDICAL RESULTS OF SCREENINGS 103

G ATTENDANCE SIGN-IN SHEET 105

H CENTER LOGS FOR MONITORING KEPT, BROKEN, AND CANCELLED APPOINTMENTS AND RECORDING UNANTICIPATED EVENTS . . .107

I MEMORANDUM TO DOCTORS. 110

J AGENDAS FOR PLANNED WORKSHOPS AND HANOUTS. 112

K DOCTORS' UNANTICIPATED WORKSHOP AND LETTER 120

L EVALUATION OF PRACTICUM. 123

LIST OF TABLES

Tables

1 Pre- and Post-Survey Attitude Test Results 53

Figures

1 Pre-/Post-Attitude Test Graphical Comparison/Question 1. . . 52

2 Pre-/Post-Attitude Test Graphical Comparison/Question 3. . . 55

3 Pre-/Post-Attitude Test Graphical Comparison/Question 4. . . 56

4 Pre-/Post-Attitude Test Graphical Comparison/Question 5. . . 58

5 Pre-/Post-Attitude Test Graphical Comparison/Question 6. . . 59

6 Pre-/Post-Attitude Test Graphical Comparison/Question 7. . . 60

7 Pre-/Post-Attitude Test Graphical Comparison/Question 8. . . 62

8 Pre-/Post-Attitude Test Graphical Comparison/Question 9. . . 63

ABSTRACT

Preventive Pediatric Health Care through Parental Involvement. Sarah L. Mack, 1989: Practicum Report, Nova University Ed.D. Program in Early and Middle Childhood.

Descriptors: Inner city clinical personnel, children's health records, preschool children, parents, agency's staff, pre- and post-tests, oral and written assignments, telephone calls, conferences, appointment logs/health posters, workshop agendas, pediatric interns.

This practicum addressed the problem of parents not assuming responsibility for their children's health care. Many of the parents failed to keep scheduled medical appointments for their children. They also lacked knowledge of the required screenings and the meaning of the results.

The goals were (1) to ensure preventive and follow-up health care in children by increasing parents' use of available medical resources; (2) to provide continuous education to parents in pediatric preventive health care and therapeutic practices.

A 12-week program was implemented for 100 parents who had children aged 3-5 enrolled in an urban preschool center. Three workshops taught comprehensive and preventive health care for children. Surveys tracked parents' inhibitions and unease toward the community clinics. A system of communication was established between the centers and the clinics.

All the parents exceeded the educational objectives. With extensive reinforcement and cooperation by the centers and the clinics, 96 of 100 parents kept all their children's ongoing appointments. These results indicated that when parents are provided the opportunity, they can learn preventive and curative well-child health concepts. If the atmosphere for learning is a nurturing environment with parents and providers sharing equal partnership in children's health, parents will assume responsibility.

CHAPTER I

INTRODUCTION

Description of Community

This practicum took place in the inner city portion of a large old midwestern metropolitan area; the community under consideration is often referred to as the "ghetto." The city was once known and recognized for its flourishing steel mills and other industries. It is a large city on the border of Lake Erie with an expanding university and a community college which adds a touch of class to the inner city. Hospital clinics, health care facilities, and human resources are added attractions in that community.

In 1985, this urban community had a population of approximately 538,800 (Cleveland Public Library). The residents comprised very diversified groups of minorities. For example, 65% of the population was black, 25% was caucasian, and 10% was Spanish American and others. Most families had a mean income of $7,000-8,500, depending on the number of family members living in that household. The majority of the families' incomes derived from public assistance, social security, or low-wage employment. Approximately 85% of the households with small children were headed by one parent. In many instances, the one-parent

family unit included others, referred to as "extended family members."

The predominant physical structure in this community is overcrowded houses or units that are poorly maintained by the owners. Several large churches stand tall with various types of architecture. Numerous disabled vehicles and abandoned dilapidated buildings reflect the transient lifestyles of the residents. Employment is quite limited and confined to fast-food chain restaurants. Grocery stores in the community are small and not cost effective. Libraries are often small units found inside of other human resource buildings, and are usually open to the public only from 12:00 PM until 6:00 PM.

There are many preschools in the community, most of them federally funded or subsidized by other means. Others are operated by private owners and are quite costly. However, there is a shortage of quality, safe, and affordable day care services in the community for poor working families. There are a number of public schools, although many children are bused to various other schools throughout the city. In essence, this urban community reflects the lifestyle of a disadvantaged population.

The responsibility of parents for their child's health care and maintenance can be seen in the program in which the writer is involved. For instance, parents who live in the community seem to want the best for their children,

however, they appear unaware of routine medical care for their children and the strategies needed to seek, pursue, and obtain it. Therefore, it was essential to establish a preschool program that met the comprehensive health care and other basic needs of urban children and their families.

The child care program under consideration was founded in the summer of 1965. The founders' premise was that all children, regardless of race, creed, or color, shared a common goal, the basic need to survive, grow, and develop. They believed that disadvantaged children and families would benefit from a comprehensive health, nutrition, education, social service, and parent involvement program. Initially, it was classified as a pilot program whose purpose was to provide comprehensive services to disadvantaged young children and families. The program was developed under the auspices of a large inner city church council which hired professional child care workers to write proposals and obtain funds from the federal government for operation of the program. Each year thereafter, federal funds have been allocated for basic operations. The program's purpose has not changed.

The program was 23 years old in 1988. Much like an infant, it has progressed through stages of growth and development before reaching adulthood, but not without growing pains, frustration, and other complications. The program is now recognized nationally as well as

internationally. It is considered a "family program," delivering comprehensive services to children of low socioeconomic level and their families.

Writer's Work Setting and Role

The preschool child care program is the second largest of eight similar programs located in this metropolitan midwestern city. It services 770 low socioeconomic-level minority children between ages 3 and 5. The program is housed in 20 local churches, housing projects, and synagogues. The children attend sessions at the centers in groups of 18-20. Three hundred and eighty-five children attend the morning sessions and the same number attend the afternoon sessions. Each session lasts 3-1/2 hours, Tuesday through Friday. The program follows the same calendar as that of the public school system.

Due to the large number of children and families receiving the various services, 110 people are employed in the program. The child care program is built on a hierarchical structure. The administrative staff consists of a program director with a master's degree in social work, a health specialist who is a registered nurse, and a counselor, an educational director, an assistant director, and one supervising teacher. All of those in education hold degrees in early childhood education. There are two medical assistants, one of whom is a licensed practical nurse and

the other attending college to become a registered nurse. There are three transportation drivers, who transport the children, staff, and parents to various medical facilities for screenings and follow-up treatment.

The administrative staff is accountable to officials in local, state, and federal governments. Two local boards function with the agency: the Corporate Board and the Parent Policy Board. The Corporate Board is comprised of professionals and laymen. In contrast, the Parent Policy Board is made up of parents whose children are currently enrolled or have previously been enrolled in the program. At the program centers, the employees are referred to as "center staff," which consists of teachers and parent counselors. There are 70 female teachers, 1 male teacher, and 20 parent counselors. Twenty-five of the teachers hold 4-year degrees in early childhood education, and the remaining 54 are attending local colleges or universities. All 20 parent counselors have been trained in social service work. Primarily, their functions are to serve as resource persons to parent One of their roles is to assist in making medical appointments and then to monitor those appointments and referrals up through completion. In addition, parent counselors assist parents to find solutions to family problems and stressful situations.

This writer was a health specialist whose role was to plan, arrange, and monitor the delivery of health services

and treatment for all children in the program. She had two part-time medical assistants. The health specialist was responsible for overall planning, administration, and implementation of the total health component of the program. Her responsibilities included:

1. serving as health planner; preparing and updating health plans, health budgets, and reports to be submitted to the grantee, regional and national offices, and the Office of Child Development;
2. supervising and promoting team cooperation in the provision of health services to children in the program;
3. facilitating the organization of the Health Service Advisory Committee and utilizing the committee in the planning, implementation, and evaluation of the health component;
4. promoting active parent involvement in the total health program;
5. arranging for screenings, diagnostic evaluations, and follow-up services for all children, and linking the child and family into an ongoing health system;
6. identifying and utilizing state and local resources for the health program;
7. maintaining updated individual health records on the children;
8. developing the center staff's team approach to the delivery of health services to children in the program;
9. integrating health education into the total child care program and helping to provide health education for parents, staff, and children;
10. participating in on-the-job training sessions;
11. compiling and analyzing data on the effectiveness of the health service component;
12. serving as an advocate for child health;

13. interpreting a handicap's functional diagnosis to the teachers and parents;

14. assuring that the education program meets the child's needs;

15. assisting and monitoring the purchase, preparation, and delivery of food to the center sites;

16. organizing a Health and Nutrition Committee (parents, administrators, and center staff);

17. assisting the health/nutrition committee in the planning and writing of cycle menus, quarterly;

18. monitoring, along with education component staff, the food services in the centers;

19. reviewing nutrition assessment records, in order to:

    a. make referrals when necessary,

    b. plot weights and heights on children's health records, twice a year in spring and fall,

    c. provide nutrition counseling to parents and staff, when necessary,

    d. provide nutrition education to parents, children, and staff, throughout the school year, and

    e. confer, report, and submit monthly reports to the grantee's nutritionists and health specialists monthly, mid-year, and annually;

20. attending scheduled meetings and workshops;

21. supervising the two medical assistants;

22. conducting multimedia First Aid and Common Childhood Disease classes for parents and staff.

CHAPTER II

STUDY OF THE PROBLEM

Problem Description

According to the federal guidelines stated in the Program Performance Standards, specific medical screenings for the children are mandated. Each child is to receive a complete physical examination, hematocrit or hemoglobin values, lead test, assessment of immunizations, screening for vision acuity, and tuberculosis test before attending class. It is the parents' responsibility to have their children's medical assessment completed before admission to the center.

But the paremts were not assuming responsibility for well-child care. They were not often clear as to what constituted a complete pediatric physical examination, and did not know how to monitor it or interpret the results. And with an overload of cases in pediatric clinics and a shortage of medical staff, many screenings were neglected by the clinics or had to be rescheduled. For many parents, rescheduling was not feasible. So appointments were frequently not kept and screenings were not done.

The writer recognized that the problem of rescheduling appointments was further compounded by the school's 90% required daily attendance. Therefore, the program director

decided to admit children even without their vision, dental, and hematocrit screenings. Pediatric dental and vision resources for disadvantaged children in this community are limited; for example, it often took two or three visits to the clinic before a dental examination could be completed.

So this writer arranged for the vision and dental screenings to be done by contractual services for any child who had not yet had them (see Appendix A). All dental and vision screenings performed on children enrolled in the program were paid for by Medicaid or by the Agency. After completion, parents were informed in writing of the screening results. They were encouraged and expected to follow through with recommended follow-up therapy for children whose screenings showed abnormal findings.

The writer had seen verification that parents were still not making or keeping scheduled pediatric appointments for the remaining blood work or the follow-up therapy. The writer and staff frequently suspected them of dishonesty in meeting the writer's and staff's request for cooperation. Parents often reported that clinic personnel had lost their child's health records (without the child's health record, no routine care could be rendered). They also complained that well-child clinics were overbooked, and appointments could not be obtained for 3 to 4 months. A routine physical examination was not done during a visit if the child was ill.

Parents tried to avoid confrontations with the writer or the center staff. Their children were brought to the centers and picked up by neighbors, friends, or relatives. In some cases, parents could not be reached because they did not have telephones. Since the centers were inadequately staffed, the time allotted for home visits was limited. The upshot was that those children identified as having medical problems were not receiving the prescribed follow-up treatment. The lack of parental involvement in health care and follow-up treatment was reflected on the program's monthly and annual reports as "noncompliance."

The problems was also recognized by the center staff and health specialists in other programs. Realistically, unmet health needs in children affect the teachers' modes of teaching at the centers. Teachers reported that children who cried or were irritable interfered with classroom learning and discipline. The child who was diagnosed with impaired vision but not treated often demonstrated difficulty in learning classroom activities, such as manipulating educational toys. In addition, children who were "sickly" and were not under medical supervision had poor daily attendance. Frequent unkept appointments prolonged the medical treatment plan that had been scheduled for completion within a designated time frame.

Problem Documentation

The problem of parents not assuming responsibility for their children's health care was demonstrated in support letters by center staff (see Appendix B). Another verification was the need for contractual services by private providers. It was the consensus of the center staff that it was difficult to get parents to obtain screening results from clinic laboratories; evidence and documentation presented in support of this conclusion is noted in written letters from staff and the health specialist. Children's health records also showed evidence of incomplete medical screenings and inadequate follow-up. The children's records reflected low hematocrit and hemoglobin values or no values recorded. The program's nutritionist described these children as "at nutritional risk." Immediate intervention is necessary for any child who has a hematocrit value below 34% or a hemoglobin value of 11% or less.

These data are collected, compiled, and reported monthly to superiors at the local, regional, and federal levels, and used nationally for statistical comparison with similar child care programs in the city and throughout the United States. The data are also used to provide programmatic training and to predict future directions for program improvement.

Causative Analysis

The problem of parents not assuming responsibility for the health care of their children stems from numerous causes. Perhaps the first and foremost is poverty. Lower quality of life and lifestyle among the poor contributes to the lack of parental involvement in well-child care. The writer is convinced that good health in children and parental involvement derives from a way of life. Personal experience with parents living in the urban communities has convinced the writer that they have not learned adequate survival skills. The parents demonstrated deficient skills in housekeeping, budgeting, child care, and getting the most for their dollar. For parents who were not taught such basic life skills, dependency is encouraged and personal decision making is discouraged.

Polnay (1984) referred to the causes as a function of parents who themselves had had an unsuccessful childhood, living in a wretched environment with inadequate dietary intake and no education in basic health principles. Ames (1981) too believed that the wretched conditions of poverty were a major culprit in parents' failure to be responsible for their children's health care. Polnay indicated that the responsibility did not devolve solely on the parents; it also involved the system. Ames (1981) recognized that parents' failure to become involved in the use of hospital and public clinics interlocked with their poverty, lowering

their self-esteem and motivation even further. Inadequate parental involvement and low socioeconomic condition created a trap from which it is difficult to escape.

Polnay (1984) felt that no one approach met the needs of all low-income families. Therefore, he recommended that health programs should be based on the needs and characteristics of the targeted group.

Another contributing factor was that the health delivery system was not sound. There was a shortage of medical staff and limited funds allocated by government. The clinic settings were not always attractive. In many cases, parents avoided using public health facilities when they were required to wait for long periods in impersonal clinic waiting rooms. Parents arrived at the clinic, usually after having taken several buses. Also, the average parent had two to three children younger than five years old who were accompanying her to the clinic.

A second major element was parents' lack of knowledge of preventive health concepts. The National Center for Clinical Infant Programs (1986) stated that most lower social class pregnant women do not receive adequate pre- or post-natal care. These parents often do not see a physician until after their first trimester. Others wait longer or are not seen at all. Premature babies with low birth weights are often born to low-income parents and high school dropouts. Other deviant health problems were venereal

diseases, cardiac problems, retardation, and fetal alcohol syndrome. Ames (1981) attributed the problem to adolescent parents who constitute a population at risk. The writer agrees with both studies that teenage pregnancy contributes to the problem.

In the experience of this writer, who has worked with families living in poverty for 15 years, most parents have had less than a 10th-grade education. In many cases, they did not learn or practice preventive health habits. Therefore, it appears obvious that they cannot assume routine medical care for their own or their children's health practices.

Richardson (1987) believed that the finest medical care for the poor is available through hospital and public clinics; all that was necessary was for them to use it. He cited the cause of the problem as the facilities' inadequate management of parents' time. Durand (1979) believed instead that the system was a barrier to parents whose socioeconomic and cultural differences deterred them from using health facilities. Disadvantaged parents could not practice preventive pediatric care when they did not know what constituted a completed well-child's physical examination, which is the basis for preventive care.

Another element is parents' ignorance of the need for immunizations, nutritional assessment, dental, and other medical screenings. But the writer believes that health

professionals give no thought to uncollected garbage, armies of rats, and unlidded or unflushed toilets. Of course, infections spread from too many people living in too few rooms. But such living arrangements lower a mother's motivation and cause her to refocus her priorities. Parents become more remiss and cannot take responsibility for their children's well-being under such chaotic conditions.

A third factor is the interaction between parents and the medical disciplines (Durand, 1979). Any demoralization of parents' role by the medical staff destroys or weakens the desire of the parents to participate in the public health system and therefore in their child's health care. The writer agrees with Durand; medicine no longer functions in isolation, and a poor attitude on the part of the medical staff adds to the problem. Some health professionals have become complacent about how they provide health services to the poor; Bryant (1986) stated that many are not committed to the needs of the high-risk and minority populations. Medical professionals do not take sufficient time to interact positively with parents. The doctor often fails to recognize that he and the parents share in the child's welfare. The Virginia State Division for Children (1981) reported that parents and providers must work together; health professionals' responsibility to convey preventive health concepts to parents is as important as parents' responsibility to take their children for screenings,

immunizations, and follow-up, as the basis for preventive health care even when the child is not sick.

Most parents express a desire for their children to be healthy, but certain barriers keep them from achieving this goal. It perplexes the writer that professionals and educators, especially those who are themselves parents, are intolerant of low income parents who miss scheduled clinic appointments. The cause or causes of broken appointments should be investigated. Parents should be encouraged to discuss the actual reasons that their child's clinical appointment was not kept.

Bryant (1986) discusses a fourth factor, those hard-to-reach families. These are the families with the most medical problems. Furthermore, they are in need of immediate intervention. This group of people places less emphasis on health as a priority. Inadequate living arrangements and overcrowded housing expand the problem. Health care alone cannot have much impact unless it includes other factors that alleviate poverty, inadequate dwelling space, and other social conditions. In his study, most houses or apartments had a limited number of appliances and were sparsely furnished. The family unit usually consisted of a single parent with one to four small children.

Bryant (1986) reports that parents who resist preventive medical care and avoid the use of health facilities are vulnerable and their children are usually

underimmunized. The problem is further complicated by the inability of professionals and researchers to present parents with an attractive format for well-child care. The display of over- or under-professionalism often lessens the parents' desire to become involved.

Tinsley (1987) says that the mothers' beliefs and values could contribute to the failure to use pediatric health services. Some parents believed in the ideas of "chance" and "powerful others." The implications were that children do not get sick if they are "lucky." Parents who trusted "powerful others" believed that doctors kept children well even if the parents only minimally practiced routine health habits. The writer agrees that parents' misconception of primary health care for children prevents their involvement in pediatric preventive health services.

Relationship of the Problem to the Literature

A review of the literature disclosed a number of methods, facilities, and materials that could ameliorate the problem.

In 1986, the Office for Maternal and Child Health Services verified the need to improve health services for well-child care. Also included were challenging strategies to be used by professionals who worked with such families. Eighty national programs were established to enhance and reinforce parents' awareness of the nature and extent of

children's health educational needs. Another 40 such programs were replicated in 40 different states. The purpose of the programs was twofold. First, it was to improve mother-and-child health status. Second, it was to enhance public and professional awareness of the need for quality health care for poverty-level populations.

The Office for Maternal and Child Health Services (1986) reported a number of reasons that parents were negligent in assuming well-child care on a continuing basis. These included health facilities that are too inadequate to provide continuity of health care in a timely manner, and a shortage of medical staff.

It was also indicated by the National Center for Clinical Infant Program (1986) that inequality occurred in child health services. The committee raised the concern that insufficient pediatric well-child care affected children's cognitive growth and development, as well as their physical health. Health clinic personnel cannot afford to underestimate the potential involvement of parents.

Polnay (1984) stated that parents who were "hard-to-reach" were the least aware of their children's health needs. Polnay's study was conducted in a deprived urban setting. He focused on children and their families who had been identified as being at risk. He believed that the "hard-to-reach" populations are easily identified; for

example, they are transient even within the community, and many children are seen only in hospital emergency rooms during crises. Children in preschool or regular school who have high absenteeism and/or tardiness records are at risk and are in the "hard-to-reach" population.

In Polnay's (1984) study, small satellite health clinics were established. Comprehensive health care was made available to all minority families living in the area. Health services were provided and health and educational programs were developed. Results reported from the study were rated excellent. There was an increase in parental involvement in the health care of their children, and the children's overall health status improved. Parents working cooperatively with doctors, nurses, and school personnel could ensure improvement in parent participation in pediatric care and health educational programs, and could meet the needs of their children.

Polnay (1984) concluded that the factors inhibiting parental involvement were the lack of health and educational programs, the parents' lack of sufficient skills for survival, and the fact that medical personnel were expected to work under restricted conditions to meet health needs. Polnay also stated that health care programs open to all did not have the same merit as when targeted to specific populations.

The writer agrees that Polnay's awareness of the problem and the strategies used were practical, timely, systematic, and logically planned for effectiveness. Whenever there is a threat to survival, preventive health care is forced to become secondary. In order to achieve success in working with "hard-to-reach" populations, all contacts need to be one-on-one and done frequently.

The study of Malinoski and Gressman (1986) in a county health department also suggested that parents would participate in well-baby care if health services were accessible and coordinated, and provided continuity. They confirmed that well-child care should be integrated with health education formally and informally during clinic visits.

The small size of their community raises some questions. They reported that the small population ensured effective interaction among the various disciplines. They stated that the sample studied could serve as a framework for future planning in a larger community that advocated a client/family system. They recognized that in order for health resources and education to be effective, a program needed to be designed for that population. Their study was on a population too small to provide enough evidence to add to the collection of data for a disadvantaged population. But they recognized that in order to educate parents in well-child care, there are still other essential elements

besides the parents. Provisions must be included to involve physicians, public health nurses, and other officials. In addition, providing and integrating educational concepts and social services to clients and parents is important, and supports Polnay's (1984) findings, with which this writer strongly concurs.

Friman, Finney, Rapoff, and Christophersen (1985) showed in their study how parents were educated in keeping children's scheduled clinical appointments. They reported that parents were notified of pediatric return visits by mailed written and telephoned reminders of the time of the visit along with the name of the child's doctor. To make it convenient for the parent, parking passes were included with the mailed reminders. The results of the study indicated that parental involvement increased in obtaining routine and follow-up health care for their children, and decrease in unkept or broken appointments. Friman et al. thought that unkept pediatric appointments raised social issues and needed to be investigated.

Polnay (1984) and Backett, Melouis, and Barvazion (1984) focused on parental participation in the use of health resources. Parental involvement and pediatric care were discussed in relation to the health facilities' availability and affordability. In both studies, it was stressed that clinics' resources, designed to service low-income economic populations, should be targeted to specific

areas. The locations served should be those where health needs are the greatest. Children living in deprived communities should have routine assessments. Special attention should be given to health risk factors and predicted future illnesses that involve children. The writer concurs with the recognition by Backett et al. of three important variables: the availability, coordination, and continuity of clinical services, which are necessities for low-income families.

Nauta et al. (1980), like Backett et al. (1984) recommended that families living in urban communities should be assessed in terms of their weaknesses, strengths, and needs. Their study focused on children's medical needs between birth and age 8 years. This was considered to be a crucial period during the stages of growth and development. They discussed three major phases in an early childhood program: infancy, preschool, and early elementary school. The participation of parents was encouraged at all levels. Special attention was given to families as a unit.

Nauta et al. (1980) and Backett et al. (1984) emphasized that health resources were in place, but the services were noncomprehensive and underused. The writer strongly agreed that health programs in the clinics often contain gaps that cause parents to become frustrated and critical of health staff and the health facilities. Such sensitivity, and unfavorable experiences on the part of the

parents, make it difficult for them to sustain a relationship with child health specialists at the clinics. In the writer's own experience, parents she works with often fail to take their children for either primary care or follow-up treatment. Educating this population regarding available resources to obtain quality, consistent health care is essential. Improving and coordinating the services of medical facilities, preventive medical programs, and rehabilitation programs within their communities are stepping stones to promoting minority health care.

According to Paget and Nagle (1986), preschool settings are ideal for assessing children medically and psychologically. Polnay (1984) states that deprivation inhibits the total growth and development of children. All these authors discussed the roles and functions of school psychologists. It was revealed that an early assessment of a child's medical, social, physical, and mental status helps to identify those children with "special needs." The study of Paget and Nagle (1986) showed that the involvement of school psychologists in preschool played an important role in assessment of children's behavior and social interactions.

O'Brian and Obrzut (1986) conducted an early assessment of young children which included screening for "hyperactivity" disorders, which is of concern because of its psychological and medical impact on classroom teachers

and the children's parents. The condition is more prevalent among boys than girls. Two groups of children were analyzed for characteristics such as short attention span, level of cognitive development, and elevation of the blood sugar level. The authors reported that hyperactivity disorders were found to be influenced by genetic and situational factors, one being dietary intake. This writer supports O'Brian and Obrzut's attempt to study hyperactivity. However, their data proved inconclusive; their diagnoses were not well defined. Since diagnoses were not validated, they could not prescribe a defined therapeutic medical regime other than the traditional one: a decrease in foods high in sugar, ritalin (drug), and teaching strategies for the teachers.

Henry's (1981) study reported the use of increased psychological services in the schools. Psychological assessment has become a reality in today's preschool settings. Henry believed that "abnormal" behavior resulted from many causes. First, many parents lacked effective parental skills and education. Second, parents did not have time available to spend with their children. Henry claimed that maladjustment problems, like medical problems, would be eliminated or avoided by early assessment through medical child care clinics, education, and training classes for parents, to enhance positive parenting skills and involvement. This writer agrees with Henry's (1981)

hypothesis; any behavior modifications in children required similar changes in the behavior of parents, for which they need encouragement and help.

The National Institute of Education (1985) discussed the weaknesses and lack of continuity in services provided by health facilities. It was believed that these often prevented parents from using hospital and city clinics. The researchers established and studied eight major health and education programs for disadvantaged children. The objective of the study was to develop a cost-effective health program for vulnerable American children. The study suggested that health and human resources were in place, but that the health systems needed to be improved. For example, health care that was fragmented needed to be better coordinated, and limited allocation of government funds should be increased to update and maintain collaborated efforts with clinic superiors and staff to ensure continuity of health care. Finally, emphasis was placed on the need to establish pre- and post-natal care and immunization programs.

Banta, Higginbotham, and Levin's (1979) findings revealed more utilization of health resources through active parent participation. Their findings were from research conducted on a Child Health and Development Project, which dealt with a home-based early intervention program. They discussed the vulnerability of children between birth and

age 6 years in a study that included six counties. The researchers looked at well-child clinics and developmental assessments for disadvantaged children. They stated that medical screenings were important in young children to detect early medical and psychological conditions. In their study, parents were provided with education and training skills.

The survey was conducted for 6 months for the noncontrol group and 18 months for the control group. Analysis of covariance used on data that was taken from pre- and post-treatment demonstrated significant changes. Improvement was noted in communication skills and dietary intake in the treatment group. The parents reported that the program was helpful in two respects. Initially, it increased their understanding of child development. Second, it provided them with parental skills to manage the behavior of their children more effectively.

Banta et al. (1979) convinced the writer that early pediatric screenings should be conducted during the preschool years when most medical and psychological problems are easily identified, treated, and monitored. They studied children 3 to 5 years old, the same age range as that of the child care programs in which the writer is employed.

The Joint Economic Committee report (1983) discussed two federally funded programs that assisted in the assessment of young children's health status, Medicaid and

the Block Grant. Medicaid has specific stipulated guidelines, whereas the Block Grant provides comprehensive services to all low-income families. The results reported were that the Medicaid program was less effective and that services provided were fragmented. Children who received primary care through the Medicaid program were hospitalized more often than those serviced by the Block Grant program. The Medicaid program was focused upon crises and cure as opposed to the Block Grant, which provided preventive medicine and cost effectiveness. The Joint Economic Committee (1983) reported that although the health systems were in place, the services were not meeting the basic health care needs of the needy. The rationale given was the complications of the funding of medical care.

In the writer's analysis of the two programs, it is apparent that parents used health resources with the least waiting time and where the delivery of health services was the most attractive. This is only logical. In Medicaid pediatric clinics, parents encounter long waiting periods, crowded clinic rooms with crying children, and staff's curt responses. These barriers will no doubt continue to inhibit or limit parental involvement in well-child care. The Medicaid programs are the best health programs of any magnitude that have been offered to the poor. Their services may be fragmented, but at least a system is in operation.

Richardson (1987) conducted a study that indicated parents were interested in their children's health care. His data was collected from day care centers on questionnaires. Educational health information was provided to parents on flyers and other printed forms. In his pilot study, all materials given to parents were readable on their academic level. The parent participants involved in the study were less than 30 years old and their children were ages 3 to 5 years. The socioeconomic status of the two groups were low income or middle class. The data revealed that many of the children had not been immunized at the appropriate age, and had dental cavities and nutritional deficits; Richardson pointed out that more than 50% of the children ate junk food before meals. Other children had not received dental or medical screenings.

The study concluded that parents needed to be educated in children's health practices. All educational activities for parents needed to be integrated into the day care school's daily curricula. Also, medical staff should work as partners with parents to ensure maximum health care for each child and utilization of health facilities.

From the writer's perspective, middle class parents, like low income parents, were not all preventive health-oriented for children. Preventive health concepts have to be learned and practiced during the early years of one's life, and many parents could not give what they themselves

did not have as a child. Parents were not cognizant of the health consequences children suffer due to the lack of parental involvement in well-child care. Many health conditions could be prevented if health problems were detected early and treated. Children who ate junk food failed to consume nutritious dietary intake at mealtime. For some families, regular mealtimes did not exist.

Ames (1981) expressed concern and described medical screenings for children as less than optimal. Ames conducted a study on the health care of children in 65 counties located in the state of Alabama. She found that immunization programs for preschool children were almost nonexistent. For the majority of the children, there was also a lack of dental care in the form of restoration, oral hygiene, prophylaxis, and space retainers. She attributed the unmet health needs in children to many causes. Many of the reasons were common and similar to the ones Richardson's (1987) later study pointed out: inadequate services, limited funds, shortage of medical staff, and lack of parental involvement in their children's health programs. Richardson believed that lifelong habits, learned in childhood, were difficult to change in adults. He indicated that many parents displayed good intentions in accompanying their children to well-child clinics, but become over-burdened with other problems. Ames claimed that the parents' lack of responsibility in pediatric child care arose from a sense of apathy associated with ignorance.

The writer agrees with the findings and the reasons in Ames (1981) and Richardson's (1987) studies. The unmet medical needs of poverty children are true. For example, the number of children who have not been immunized, especially age-appropriately, is astounding. But there are some positive built-in mechanisms in the system that encourage parental participation in the health of their children. Strategies executed by the Health Department have been beneficial on behalf of children. For example, children are not accepted into the writer's and similar programs unless immunization status meets the program's requirement. Children are not accepted into kindergarten classes until they have received the required immunizations. The writer concurred with the authors' methods of intervention. Parents need to be taught educational concepts. Allocation of federal funds needs to be increased so that additional medical staff can be employed. Increased staff could decrease waiting periods at the clinics and provide health materials based on the parent's educational backgrounds.

In conclusion, the literature shows the importance of well-child care in young children. It was revealed that parents needed to be involved and assume responsibility for their children's health care. Many of the causes were identified and addressed that deterred or inhibited parents from utilizing existing health resources.

The writer was cognizant that the problems discussed are crucial to the well-being of children. Many of these factors have been of concern to educators, professionals, and researchers. The strategies suggested in the literature review provided directions for solutions to the problem. The objective was to improve and enrich the lives of children and their families living in poverty, by educating parents to assume responsibility for preventive health care for their children.

CHAPTER III

ANTICIPATED OUTCOMES AND EVALUATION INSTRUMENTS

Goals and Expectations

The development of a parent involvement program is essential to the comprehensive care of young children. It is imperative that parents understand the types of health screenings that are included in a routine annual physical examination and their implications. The first goal of this practicum was to ensure preventive and follow-up health care in children by increasing parents' use of available medical resources. The second goal was to provide continuous health care for children and therapeutic practices by parents.

Behavioral Objectives

It was suggested by some of the researchers in the literature that if parents were more knowledgeable about children's health practices, they would keep more pediatric appointments.

In the attempt to educate or increase parents' awareness, an understanding of well-child medical screenings, results, and implications would increase parental involvement in their children's preventive health care. Therefore, the following four specific behavioral objectives were chosen for their appropriateness for this practicum:

1. Each parent would demonstrate an understanding of why medical appointments are important and should be kept.
2. Each parent would name three out of seven screening tests that their children should be receiving during their annual physical examination.
3. Each parent would be able to explain and interpret the results of three medical screenings out of seven that their children should be receiving.
4. Each parent would state orally the medical procedures for follow-up treatment if necessary.

Measurement of Objectives

The first objective was measured by a 10-item pre- and post-attitude questionnaire (see Appendix C) designed by the writer to assess the parents' attitudes toward health providers and the use of health clinics. It was based on a five-point Likert Scale, and was administered during the implementation of the practicum. It elicited responses from the choice of the following words: "always," "usually," "sometimes," "seldom," and "never." The Likert Scale allowed the writer to evaluate other problems that inner city parents encountered in pediatric urban health facilities. The attitudes expressed on the questionnaire were the springboard for workshop discussions to inform and enlighten parents about typical situations that could be

perceived and misinterpreted, so that if they encountered any similar situation they would know how to respond appropriately. The questionnaire thus functioned as a needs assessment, and was used to develop other topics that were incorporated into the agenda.

Physical examinations and screenings of the children were being scheduled all during this time. Objectives two and four dealt with these medical screenings. Each parent was first provided with a list of seven screenings, their explanation and interpretation, and their prescriptive follow-up treatment (see Appendix D).

Based on these materials, objective two was for all parents to be able to name three out of seven screenings required in the pediatric physical examination. It was measured by a written exercise in which parents were asked to write down as many of the seven as they remembered (see Appendix E).

The third objective was measured by an oral activity assignment (see Appendix F). This activity was structured to allow each parent an opportunity at his or her own level of understanding to explain and interpret medical results, based on screening tests. The participants were asked to explain the reasons for any three tests of the seven, and to differentiate normal from abnormal results--for example, that a blood hematocrit value under 34% or hemoglobin under 11% indicates anemia. The activity and the ensuing

discussion were designed to stress the importance of early detection of any abnormality.

The fourth objective was measured by oral activity (see Appendix F) in which each parent stated orally in a whisper to the writer or her staff the follow-up procedures that had been emphasized in the workshops or by medical staff. This device required the parents to recall and verbalize the basic steps in the follow-up procedures. This type of measurement was useful in that medical languages were being taught. Also, the terms and procedures generated questions for further discussion.

There were several other evaluation instruments. Two logs were kept at each center. One log kept track of kept or broken scheduled appointments. The other log was used to record any unanticipated events as they were reported. Parents signed in at workshops, and attendance records were kept (see Appendix G). The logs at each center were reviewed each week and checked against children's health records in an effort to ensure that parents were indeed keeping scheduled appointments as they reported (see Appendix H). The children's health records were used to evaluate whether the medical staff had covered all the preschool requirements.

Mechanism for Recording Unexpected Events

When one plans a project which lasts for an extended period of time, provisions should be made for unexpected occurrences. In the attempt to accommodate them, the author kept a weekly log for each preschool center involved in this practicum (see Appendix H).

CHAPTER IV

SOLUTION STRATEGY

Discussion and Evaluation of Solutions

In the effort to increase parental involvement in well-baby care, the application of certain strategies is imperative. A review of the literature disclosed a variety of methods that are applicable and practical. However, the problem is chronic and interrelated with various intricate factors. For example, teenage pregnancy breeds poverty, minimum wage employment, high school dropouts, and poor nutrition habits. Any strategies offered as solutions must be specific and succinct. Those who contributed solutions were individuals in the field of medicine, professionals, educators, communities, and federal, state, and local officials.

A number of writers focused on the health delivery system. Durand (1979) and Bryant (1986) both concentrated upon increased usage of medical clinics to treat disease. Durand stated that the problem would be resolved if health facilities were in place and functioning to meet the unmet needs of children and youth. Bryant believed that lack of availability was not the problem. He was convinced that the key was parental negligence, since some health facilities were available but were not being used. He further

contended that many of the illnesses and diseases that affected blacks and other minorities were treatable and preventable.

The writer does not support Bryant's (1986) hypothesis. It lays the responsibility on the poor population but offers no strategy for alleviating the problem. Other writers saw more room for improvement in the health delivery system.

Nauta et al. (1980) and others reported solution strategies that would have a positive impact on alleviating or minimizing gaps in the delivery of health services to children, to encourage parental involvement. They described the results as improvement in staff/parent interpersonal relationships and organization of health care, and fewer hours that clients must spend in the pediatric clinics. The writer agreed that many barriers that affect parents' usage of health services should be eliminated. From past experience in working in health care systems, the writer could attest to parents waiting long hours in impersonal clinics. Some children often become restless and are difficult to discipline. She agreed that if such conditions were abolished or modified, parents would be more inclined to use pediatric services at the clinics.

Malinoski and Gressman (1986) indicated that health care institutions need to make changes in order to eliminate the existing barriers. It would be helpful if health providers provided and ensured an increase in accessibility

and continuity in health practices and services. They also offered strategies to improve staff attitudes toward parents and improve communication skills.

The Virginia Division for Children (1981) suggested some directions that could be helpful. Their committee viewed the physical settings at the clinic as a deterrent to parents' utilization of health resources. Another barrier was the staff's lack of sensitivity to low-income families' lifestyle. The committee believed that the medical disciplines should be educated in practices and procedures for the delivery of health care to the poor. This writer supports the findings in the study that health is not viewed as high priority among low-income families, especially preventive health care. Therefore, they may not arrive on time or keep their clinic appointment. She believes that consideration should be given to broken or unkept appointments. Usually there are underlying social reasons other than a display of apathy for unkept or broken appointments. Medical staff who administer health care to poverty populations should also be taught to be caring and sensitive to socioeconomic differences.

Durand (1979), like Bryant (1936), presented strategies that could contribute to the solutions of the problem. However, Durand's approaches seemed to be more realistic than Bryant's. Durand believed that the elimination of fragmented and duplicated health services would encourage

parents to obtain primary care for their children. She indicated that long hours parents spent at the clinic could be decreased. Also, children's physical examinations could be completed at one visit as opposed to several. Her study showed in addition that the family unit needed to be strengthened and supported instead of being criticized or demoralized. She indicated that credibility would be added to the solutions if parents and doctors become partners, making responsible decisions together for the welfare of the children. Durand also stressed that strategies, solutions and the implementation of established goals could work if they involved significant others--for example, parents, schools, communities leaders, disciplines, professional, and government officials.

The writer agreed with Durand (1979) that fragmented and duplicated child care should be eliminated, so that clinic pediatric services will be more appealing to parents. Health resources needed to be organized and delivered in the best interest of the client if they are to have any positive impact on the problem.

But in the writer's opinion, preventive health education encompasses more than increased use of clinics. She believed that preventive concepts needed to be practiced as opposed to only present disease being treated.

It was the writer's belief that two other efforts would also be helpful: improvement in urban families' lifestyles

and changes in environmental conditions. Parents should be taught that poor sanitation and poor health habits are interrelated. After years of experience in working with low-income families, this writer has observed that children's primary care goes unattended when parents are sickly. The writer, like others in the literature review, is convinced that the problem can never be completely resolved. However, it can be improved.

The writer considered survival skills and education as fundamental tools in the practice of preventive health concepts. To help parents assume the responsibility for their children's welfare, they first need to be taught practical survival and organizational skills before preventive health care can become a higher priority in their lives. These include budgeting, shopping, cooking, and child-rearing practices. It is a formidable task for parents to be accountable for the welfare of children without the knowledge of effective parenting. They need to be educated through workshops, conferences, and printed literature to gain a perception of preventable as well as treatable medical conditions. The writer believed that if parents were taught the importance of primary pediatric health concepts, they would then utilize health and human resources according to their children's scheduled routine clinical appointments, as opposed to using only crisis-oriented treatment.

Grant (1982) offered similar approaches to the problem. He contended that the cycle of poverty must be eliminated. His methods included planned parenthood, food supplements for targeted populations, and education in health strategies.

Tinsley (1987) reported that parents would become more involved in their children's pediatric health care if certain myths were dispelled. She reported that parents in her study attended well-child clinics based on their beliefs and values. The three underlying philosophies used by parents in her study were "internality," "chance," and "powerful others." Parents who practiced the "internality" approach assumed responsibility for their children's health care. Those who relied on "chance" believed that their children were "lucky" if they did not become ill. And those who believed in "powerful others" thought that the medical professionals alone were keeping their children well. She stated that empirical data obtained from the study was valuable in assessing strategies to improve parents usage of the clinics. She developed an educational program that involved collaboration and participation of parents, disciplines, and professionals to assist parents in the maximum use of children's health services.

The writer agreed with Tinsley's (1987) hypothesis that parents do practice myths as related to the health care of children. For example, "It is not necessary for preschool

children to be seen by a dentist; they will lose their baby teeth anyway," or "Baking soda will stop a child's stomach-ache." Parental education will help to dispel such myths.

Description of Selected Solution

The solution selected addressed the problem of children in the preschool program who were not receiving routine well-child care because of parents who were reluctant to seek and obtain pediatric follow-up treatment. It was designed to effect positive changes in the lifestyle of low-income families. These concerns have been discussed in earlier sections of this paper. The methods and strategies used were basic and specific.

The writer is convinced that knowledge about good health practices and principles will have an impact on the health status and lifestyle of children living in poverty. Therefore, the solution chosen was to provide health education to parents. The aim of this project was to assist parents in acquiring an understanding of the relationship between routine primary health care and wellness. They were provided with strategies that enabled them to utilize the available health resources.

The project had a three-way thrust. It was obvious that parents were not going to increase their use of the clinics if they continued to meet the same barriers, no matter how much they were taught. The medical professionals

needed to be educated as well. At the beginning of the practicum, the writer scheduled meetings with clinic directors, pediatric providers, and nurses in neighborhood clinics. The meetings were designed to accomplish several purposes. First, the medical personnel were informed of the medical requirements prior to children's admission to the preschool centers. All children enrolled in the program are required by the state Health Department to be "free of communicable disease," as established by the physical examination. Second, an effective system was thereby created for reporting the delivery of medical services to the preschool's health specialist. All verbal orders and written instructions given by medical personnel to parents were confirmed by the writer and clarified for the parents and center staff as necessary; throughout the 12 weeks of the practicum, the writer and the clinic personnel were in frequent communication. Finally, the clinic personnel were apprised of the parents negative feelings and were encouraged to make the effort to modify the conditions causing them.

The center staff was prepared as well. The writer scheduled separate weekly conferences with center staff and, by telephone or in person, with those parents who needed assistance. Conference time was used to discuss medical and/or related conditions, to share current information, to involve other agencies when necessary, and to plan

appropriate educational activities for children with special needs. The clinic did not always perform all the screenings that constitute a "completed physical examination," and the parents were not well-informed enough to request those that had been omitted (see Appendix I).

Children's health records were closely monitored weekly to ensure that medical findings were documented and acknowledged by center staff, and data control sheets were kept at each center and at the main office. The writer and center staff reviewed and compared data to verify needs, kept or broken appointments, and to document completed dental treatment. Continuous review of this instrument informed the writer which parents needed assistance in obtaining prescribed follow-up treatment.

The writer assessed each child for nutritional deficits. Children diagnosed as underweight, overweight, with "failure to thrive," or with loss of weight were weighed every 2 weeks; data was entered into the child's health record. All medical findings were reported to attending physicians and follow-up treatment was prescribed based on diagnoses. In addition, the writer participated in writing individualized educational plans as educational guides for teachers in planning activities for children with medical or handicapping conditions.

Report of Action Taken

The writer planned and conducted health and educational workshops for parents. Three workshops, with an agenda, were presented by the writer, one for each month of the practicum (see Appendix J). (Another one was conducted unexpectedly by volunteer visiting pediatricians; see Appendix K).

There were 100 parents in the practicum, all mothers whose children had just been enrolled in the preschool program for the first time. Thirty-five were between the ages of 18 and 20 years, 50 were between 21 and 24 years, and 15 were 25 or older.

The first workshop was planned to capture and maintain the parents' interest. It was also designed to foster cohesiveness among the parents participating. The writer attempted to develop an atmosphere that would be conducive to the comfort and learning of the participants. An "icebreaker" activity involving total participant involvement helped the parents to become better acquainted and also to discover their commonalities. Nutritious snacks and beverages were served, and the meeting area was decorated to reflect the tone and the nature of the workshop.

A 10-minute pre-survey test was administered to ascertain the parents' perception of the importance of keeping their children's scheduled medical appointments and

to inform the writer which health concepts needed to be emphasized. It also assessed parental attitudes and feelings toward medical personnel who worked in inner city health facilities. The theme of this workshop, which was used to accomplish objective one, was "Making Children Healthy--Keeping Children Healthy" (see Appendix J). The writer used the responses from item one of the pre-test to introduce the idea of parental assumption of responsibility for their children's health care. It was emphasized that when parents neglected well-child appointments, health needs in young children were denied care and remained unmet. This in turn frequently led to irritable attitudes, inappropriate behavior patterns, time out of school due to illness, and even permanent physical disorders. Another intent of the workshop was to impart medical information that addressed the health needs of preschool children and parental responsibilities for them. Each parent was accordingly provided with a list of seven screenings that were to be included in a routine pediatric examination, with their explanations and interpretations. Information was provided about nutrition, immunizations, and accident prevention.

Parents were told that at the primary care level, health advice from doctors and other member of the care team endeavored to educate parents about health. The concept of comprehensive care for their children was highlighted. Health providers stressed that unkept appointments lead to

fragmented or unmet primary care. Many parents reported having used several different clinics. Therefore, the writer promoted the idea of using the same facility each time. Records would then be available in case of an emergency, and one of the doctors on the team would be accessible even during non-clinic hours. They were also told that long clinic waits are often the result of unkept appointments. The clinics need to service a designated number of patients in order to retain their Medicaid status; therefore, they have to overbook to compensate for those clients who don't appear.

The second workshop continued to stress childhood diseases in preschool children, preventive concepts, and the role of parents. A 10-minute written activity was administered by the writer and her assistants (see Appendix E). Each parent was asked to write down three of seven screenings they could remember from the handouts and discussion of the previous workshop. This led to other topics for discussion. The writer also emphasized ways to access available community resources which could aid parents in obtaining and following through with recommended treatment. A great deal of attention was paid to the concept that parents and providers were partners in the providing of well-child care. Parents were encouraged to see the medical providers as human beings with their own personalities, pressures, and concerns, instead of as

distant authorities. They were also urged to pay careful attention to what medical personnel said, since their children's health could depend on the instructions given. But at the same time it was stressed that the parents also have an active role, and must not hesitate to ask questions. They were advised to write down any questions before their appointment, and to demand explanations in a form that was understandable to them.

At the first two workshops, a wide variety of literature, posters, and audiovisual aids was used to enhance parents' cognitive level of understanding. Each parent received a list of resources with telephone numbers and locations of health services available in the community.

The third workshop, which concluded the 12-week practicum, was basically a review and a call for feedback based on previously presented material. Emphasis was placed on follow-up procedures, appropriate assertiveness, post-test, and evaluation of the 12-week program.

For some parents, testing for objectives 2, 3, and 4 was incorporated into the second and third workshops, after the parents had had a chance to study the materials handed out in the first workshop. The parents were asked to individually come up and whisper to the writer or staff an explanation and interpretation of at least three screening results they had learned in the program; later in the workshop, as a separate but similar exercise, they reported

the procedures for follow-up treatment (see Appendix F). Other parents had already imparted the required information during individual conferences with the writer or other center staff.

The writer structured each workshop to last between 1-1/2 and 2 hours, but they all lasted longer. Often, many of the parents lingered after the workshops had ended to talk with the writer and to ask additional questions.

Each workshop was presented three times, once each at the centers chosen for the practicum. The workshops were open to any parent who wanted to attend, and several other parents did so; there were 30 to 40 parents present at each workshop. But the results are stated only for those 100 core parents in the practicum.

CHAPTER V

RESULTS, CONCLUSIONS, AND RECOMMENDATIONS

Results

Objective one was that each parent would demonstrate an understanding of the importance of keeping pediatric appointments. It was measured through parental demonstration, by the pre- and post-Attitude Test, and by documentation of screening results.

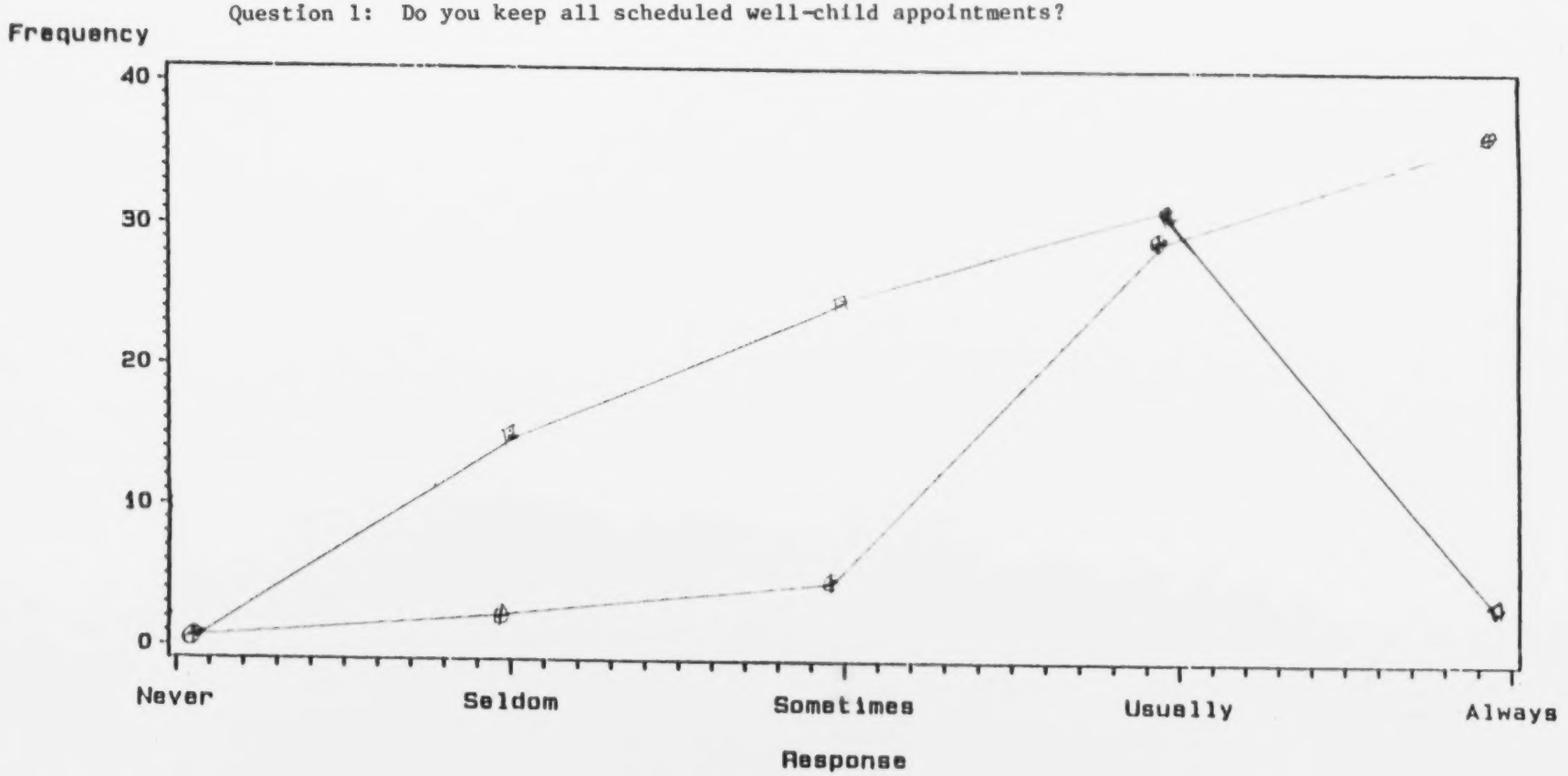
The responses on item 1 of the questionnaire indicated that prior to the 12-week parent involvement program, 77 reported that they "always," usually," or "sometimes" kept well-child appointments. After the 12 weeks, the number giving these responses had increased to 91. This was confirmed by the children's medical records: screening results and follow-up began appearing on the school records (see Figure 1).

Table I on page 53 summarizes the results of the survey.

FIGURE 1.

PRE-/POST-ATTITUDE TEST GRAPHICAL COMPARISON

Question 1: Do you keep all scheduled well-child appointments?



symbols: Pre-score red diamond
symbols: Post-score blue circle

TABLE I

Pre- and Post-Survey Attitude Test Results

N = 100

Always Pre	Always Post	Usually Pre	Usually Post	Sometimes Pre	Sometimes Post	Seldom Pre	Seldom Post	Never Pre	Never Post	ITEM
7	46	39	37	31	8	19	5	4	4	1. Do you keep Appointments?
ITEM DISCARDED										2. If not, do you cancel or not go?
10	33	40	43	30	17	18	5	2	2	3. Staff instruction understandable?
15	17	29	19	39	28	15	12	2	24	4. Do you hesitate to question?
4	27	37	47	40	12	15	4	4	2	5. Same doctor each visit?
8	5	28	15	47	30	15	29	2	21	6. Does clinic staff talk down?
7	2	32	10	45	29	5	29	1	30	7. Are you rushed through clinic?
9	5	29	13	51	29	9	18	2	35	8. Staff attitudes inhibit keeping appts?
40	5	31	18	19	3	8	31	2	10	9. Are there long waits at clinic?
ITEM DISCARDED										10. Prefer private doctor or clinic?

For full version of questionnaire see Appendix C.

The number who responded negatively--"seldom" or "never" on the pre-test--dropped from 23 to 9 on the post-test. However, this result was not reflected in action. Of the 100 parents who participated in the program, 96 kept all scheduled appointments for screenings and recommended

follow-up treatments. During the 12-week program, there were only four unkept clinic appointments, one each by four parents, which was not significant. In each case there was a valid justification.

Items 2 and 10 on the questionnaire were discarded due to their ambiguity. Item 3 on the questionnaire asked if instructions given by the doctors and nurses were explained to the parents' understanding. The results reflected a vast difference between the pre- and post-tests. On the pre-test, 50 parents responded that they "always" or "usually" understood. At the end of the 12 weeks' program, 76 of the 100 parents responded positively, "always" or "usually." The 48 parents who responded "sometimes" or "seldom" on the pre-test decreased to 22 on the post-test (see Figure 2).

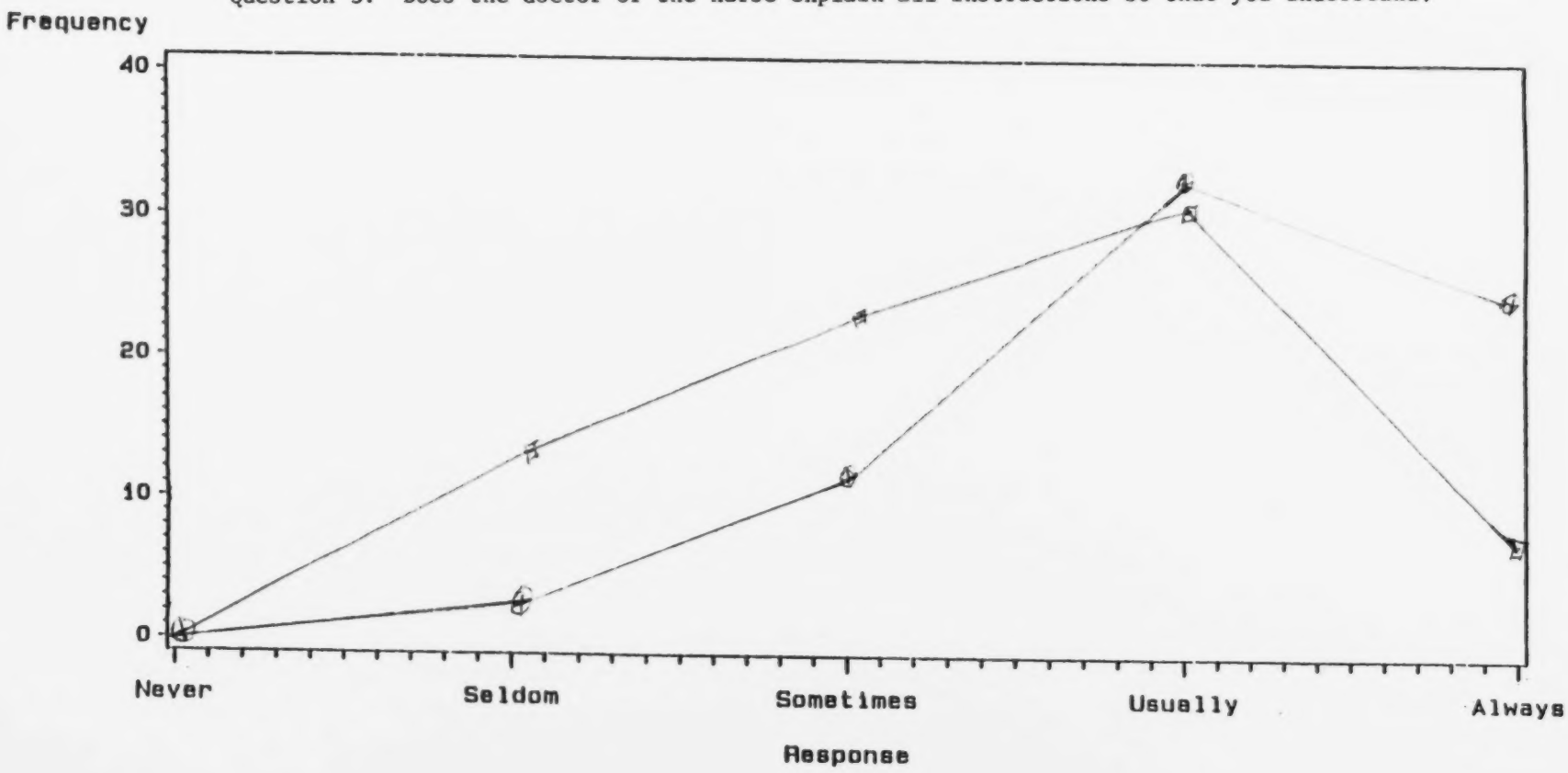
Item 4 was very impressive to the writer. This item measured the parents' willingness to question medical authorities. There was a moderate change in the scores on "always" and "usually" from the pre-test to the post-test. The most significant change was noted on the responses of "seldom" and "never." These scores increased from 17 on the pre-test to 36 on the post-test (see Figure 3), indicating that the parents felt more confident about confronting medical personnel.

Items 5 through 9 dealt with community health resources and attitudes (see Figures 4 through 8). When the parents were asked if their children were seen by the same doctor on

FIGURE 2.

PRE-/POST-ATTITUDE TEST GRAPHICAL COMPARISON

Question 3: Does the doctor or the nurse explain all instructions so that you understand?

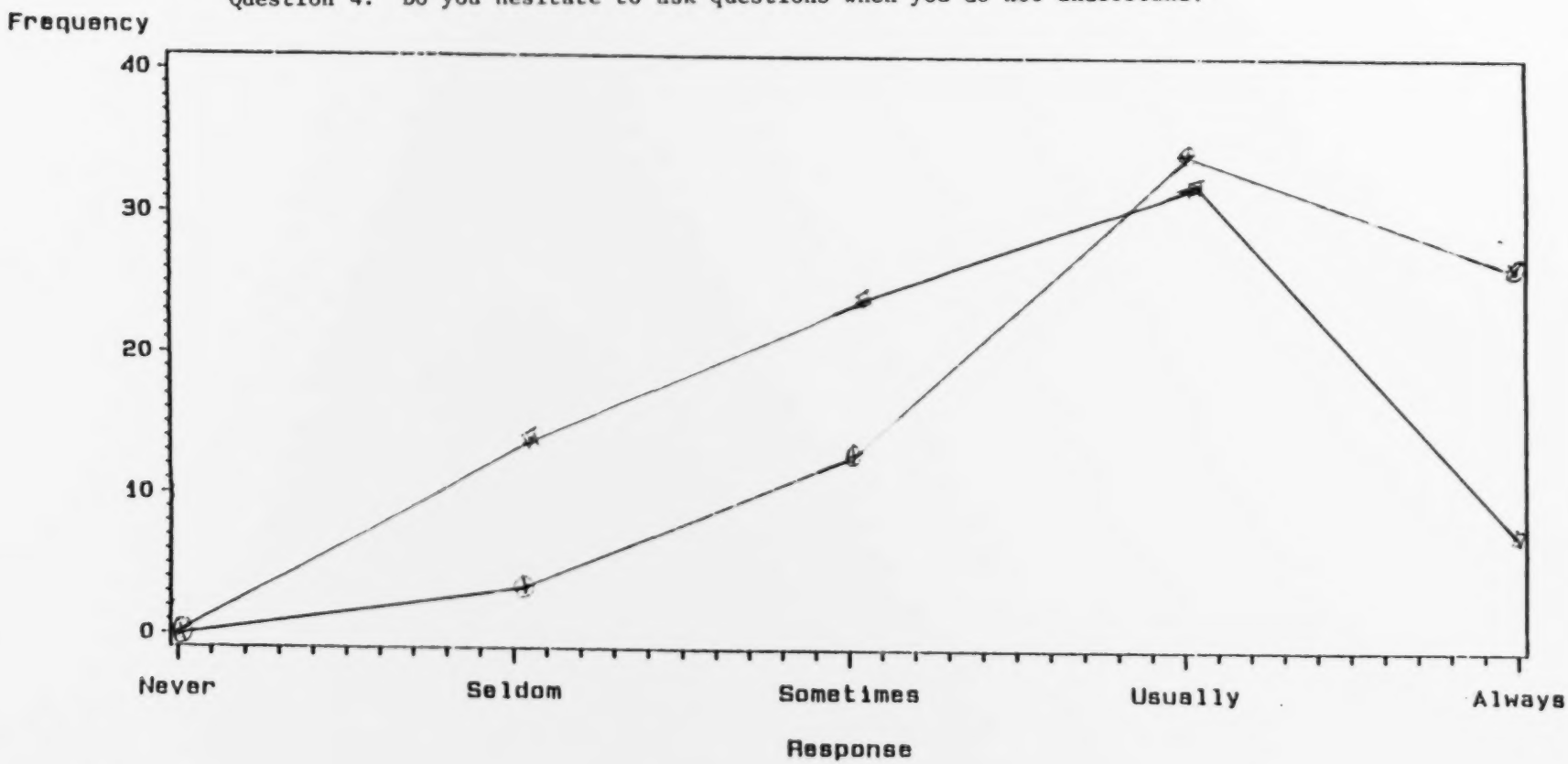


symbols: Pre-score red diamond
symbols: Post-score blue circle

FIGURE 3.

PRE-/POST-ATTITUDE TEST GRAPHICAL COMPARISON

Question 4: Do you hesitate to ask questions when you do not understand?



symbols: Pre-score red diamond
symbols: Post-score blue circle

each visit (Item 5), the pre- and post-test responses showed a dramatic shift toward the direction of more children seeing the same doctor each time (see Figure 4).

The responses on item 6 were rather interesting. The parents' uneasy feelings about the medical professionals were clearly reflected in their responses. On the pre-test, 36 parents responded that clinic personnel "always" or "usually" talked down to them. On the post-test, 20 of the 100 parents responded "always" or "usually." The 17 who had answered "seldom" or "never" increased to 50 on the post-test. The response for "sometimes" decreased by 17 on the post-test (see Figure 5).

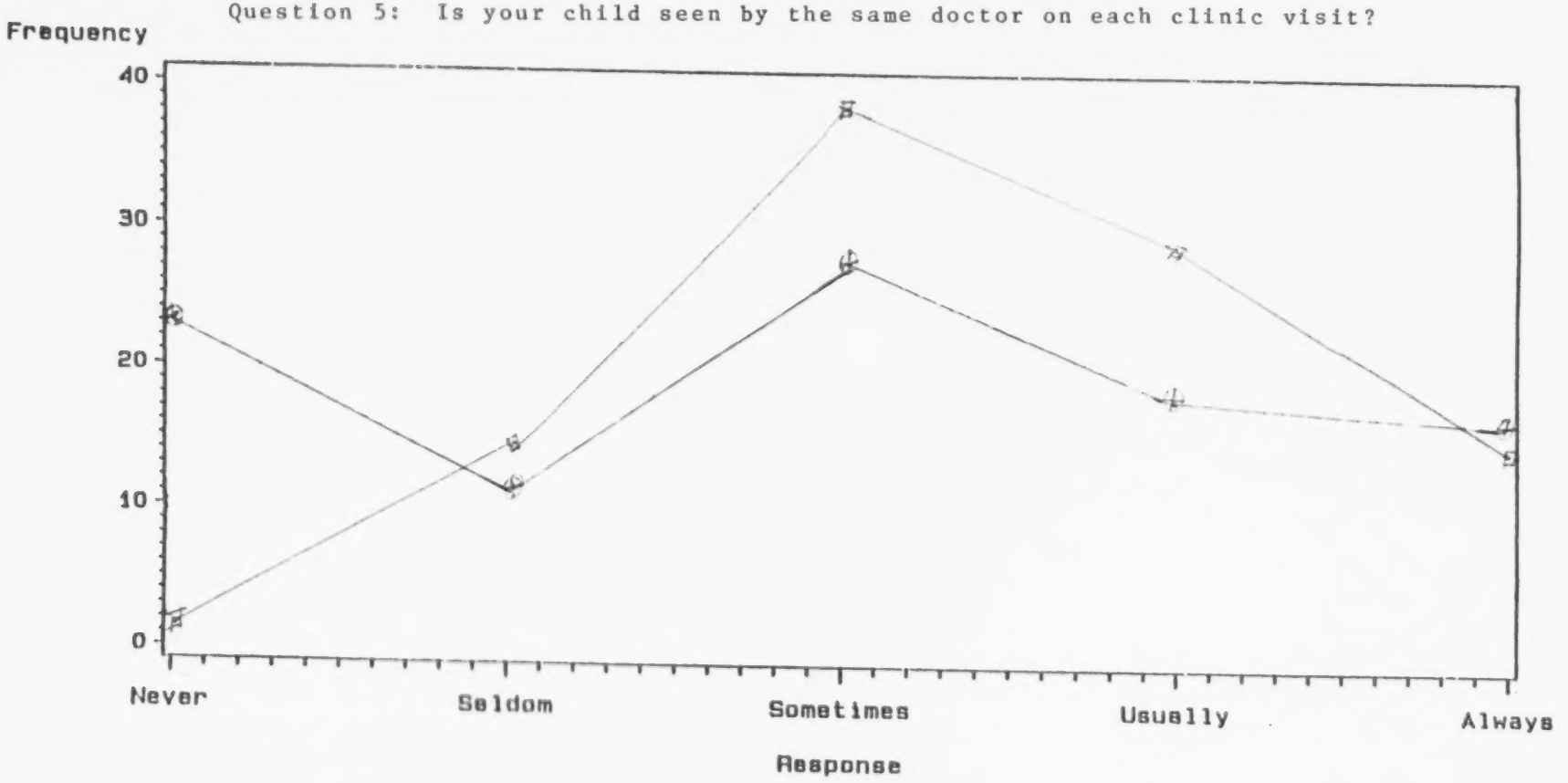
The participants' responses to item 7 (feeling rushed at the clinic) demonstrated a significant increase in establishing a rapport with the professionals in the clinics. On the pre-test, 54 responded that they "always," "usually" or "sometimes" felt rushed, whereas 17 responded that they "seldom" or "never" felt rushed during pediatric visits. In comparison, on the post-test, 12 parents said they "always," or "usually" felt rushed. Those who responded "seldom" or "never" increased from 16 to 59 (see Figure 6).

Item 8 revealed a dramatic shift from negative to positive responses. On the pre-test, 89 reported that the medical professionals' attitude interfered with their use of health facilities, whereas 11 reported "seldom" or "never."

FIGURE 4.

PRE-/POST-ATTITUDE TEST GRAPHICAL COMPARISON

Question 5: Is your child seen by the same doctor on each clinic visit?

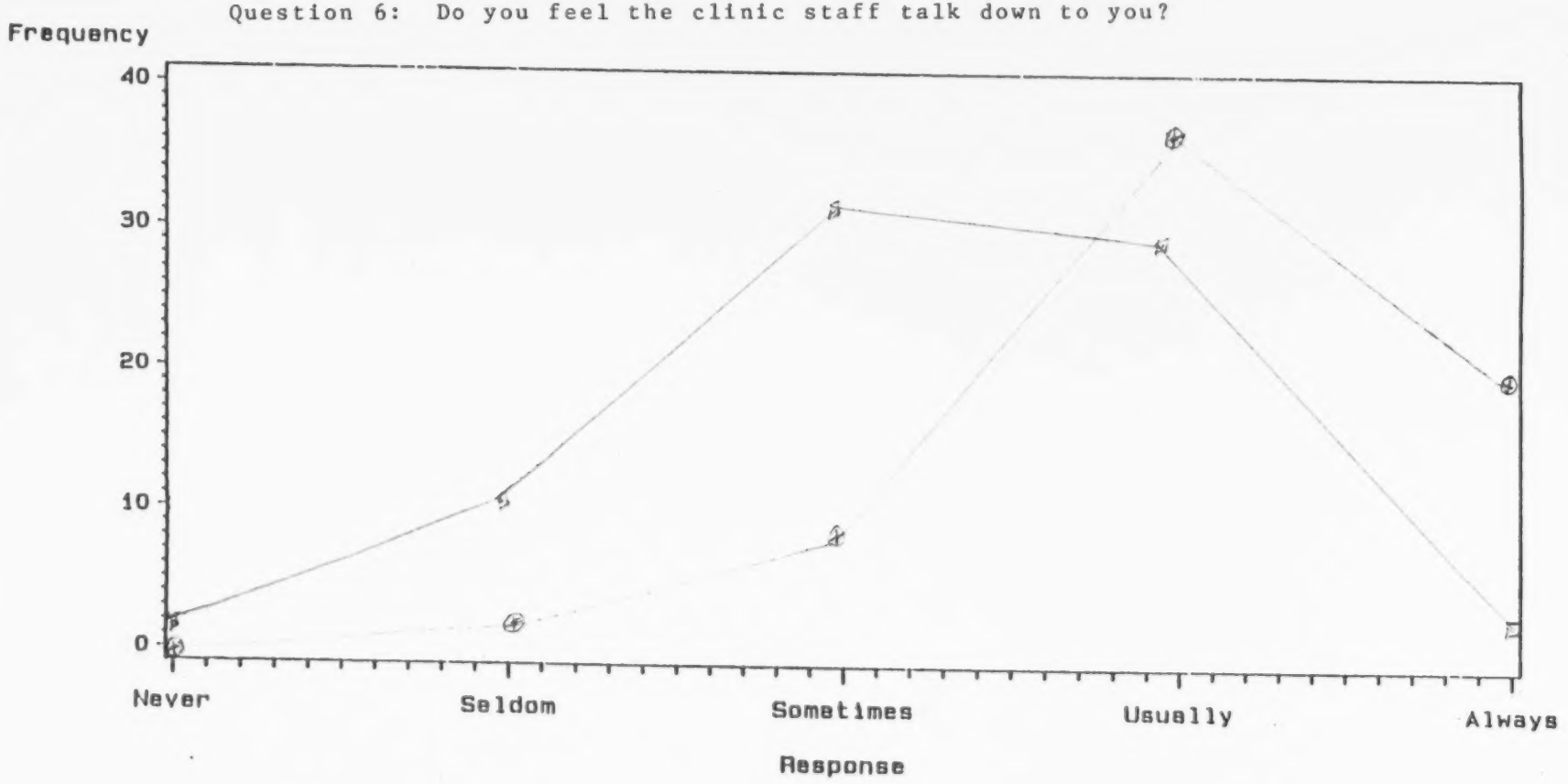


symbols: Pre-score red diamond
symbols: Post-score blue circle

FIGURE 5.

PRE-/POST-ATTITUDE TEST GRAPHICAL COMPARISON

Question 6: Do you feel the clinic staff talk down to you?

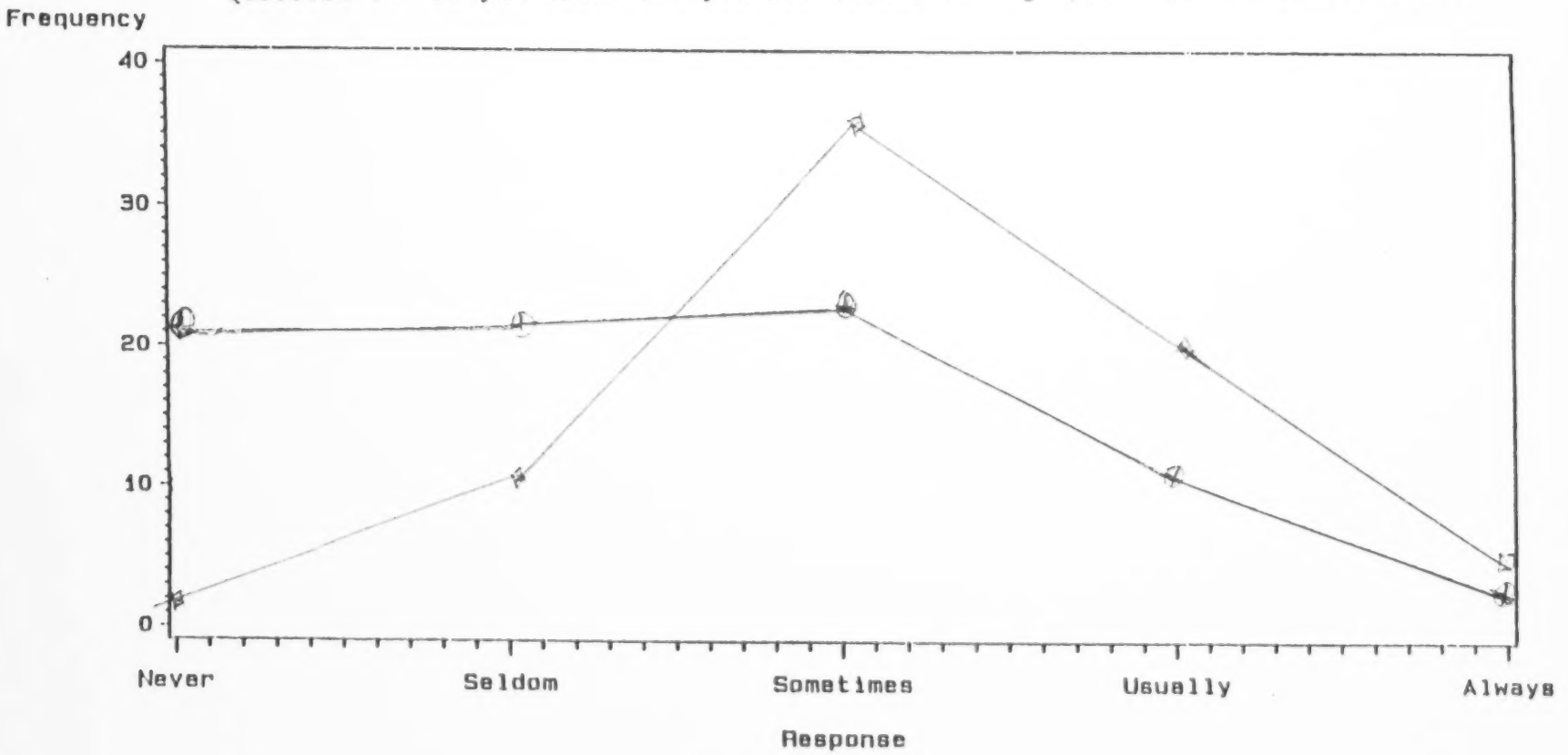


symbols: Pre-score red diamond
symbols: Post-score blue circle

FIGURE 6.

PRE-/POST-ATTITUDE TEST GRAPHICAL COMPARISON

Question 7: Do you feel that you are rushed through your child's clinic visit?



symbols: Pre-score red diamond
symbols: Post-score blue circle

On the post-test, there was a significant increase to 53 responses for "seldom" or "never," a positive direction (see Figure 7).

On item 9 there were dramatic differences between the pre- and post-tests related to waiting for long periods at the clinic on the first three responses. Ninety of the 100 parents indicated on the pre-test that they "always," "usually," or "sometimes" encountered long waits at the clinic. On the post-test, those who reported "seldom" or "never" having to wait a long time rose from 10 to 41 (see Figure 8).

Objective two, three, and four were to teach parents the components of a pediatric physical examination, how to interpret the results, and what follow-up treatment might entail. They were measured by oral and written activities. All three objectives were met successfully.

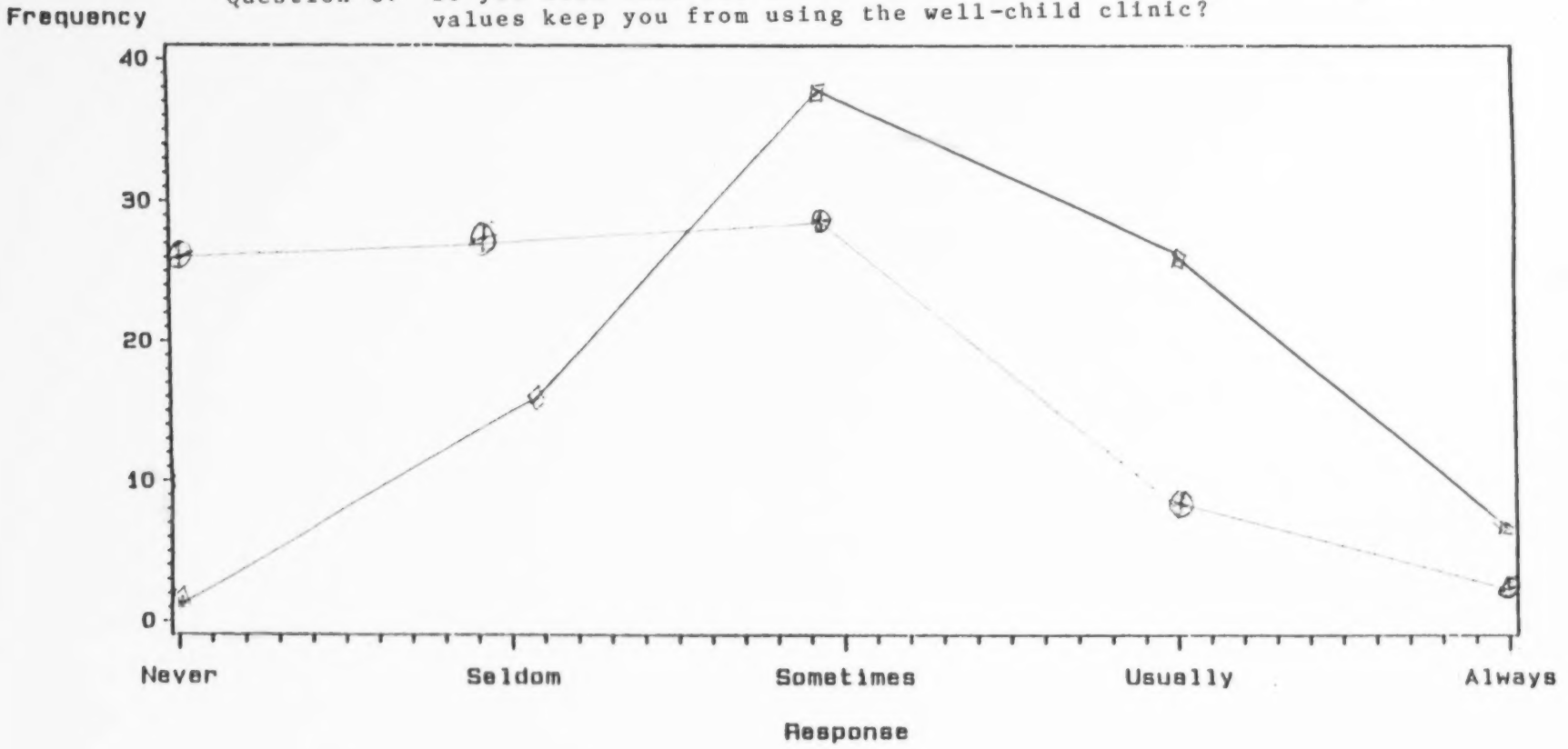
Objective two required each parent to be able to name three out of the seven screenings that their children received during an annual physical. Each parent responded to this oral activity by whispering to the writer or her staff as many names of the screening tests as they could recall. Seventy-five parents were able to name six of the seven screenings, 21 could identify five, and the remaining four parents could identify four.

Objective three was an oral assignment that asked parents to explain and interpret the possible results of

FIGURE 7.

PRE-/POST-ATTITUDE TEST GRAPHICAL COMPARISON

Question 8: Do you feel that the doctor and nurses' attitudes, beliefs, and values keep you from using the well-child clinic?

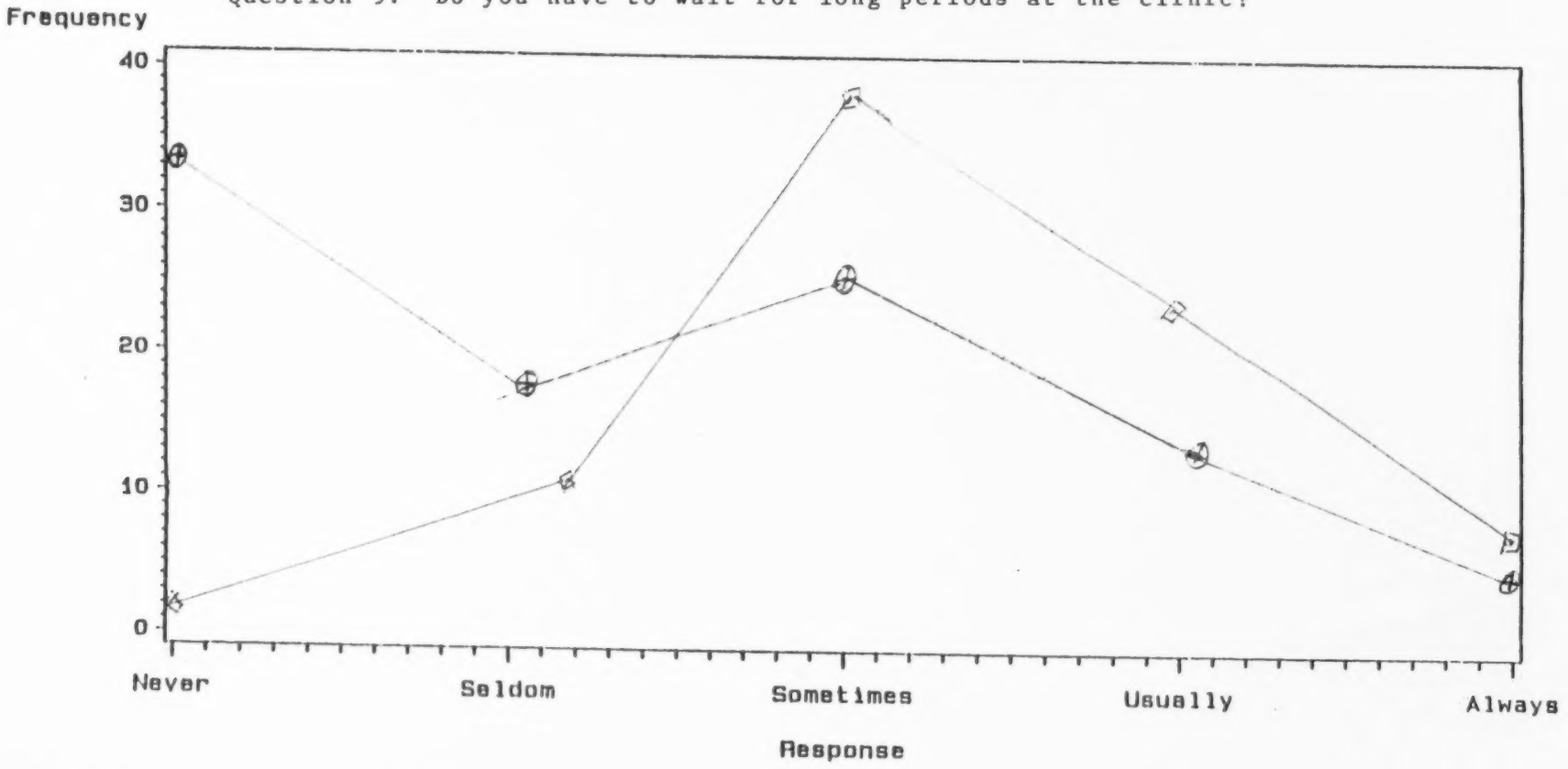


symbols: Pre-score red diamond
symbols: Post-score blue circle

FIGURE 8.

PRE-/POST-ATTITUDE TEST GRAPHICAL COMPARISON

Question 9: Do you have to wait for long periods at the clinic?



symbols: Pre-score red diamond
symbols: Post-score blue circle

three of the seven screenings. The parents again exceeded the requirements. The 100 participants were all able to recognize, with association, the outcome of each screening result. Many of the parents were able to provide more detailed information about some of the screening test results than others. These were the ones who had read handout materials and participated in the parents' workshops. They reported that they asked the doctors and nurses questions and insisted that all instructions be explained to their understanding, reflecting the answers given for items 3 and 4 on the questionnaire.

Objective four was met favorably by each of the 100 parents. Forty-seven of the parents expeditiously reported a thorough account of the follow-up procedures. Thirty-two of the 100 parents verbalized the follow-up procedures with a minimum amount of assistance from center staff, medical assistants, and the writer. Twenty-one of the remaining parents verbalized the follow-up procedures, but required more assistance and took a longer time to complete the assignment than the second group of parents.

At the conclusion of the practicum, the center staff had had to take only one child for a clinical appointment, to the dentist.

Conclusions

The objectives were successfully met in this 12-week practicum. The hypothesis was that if disadvantaged parents are provided with the opportunity to learn preventive and curative pediatric concepts, (1) they will increase their involvement in their children's preventive health care, and (2) they will establish a positive rapport with pediatric providers.

Based on this practicum, it was evident that parents who learned about well-child health care did assume more responsibility for their children's pediatric primary care. They demonstrated knowledge about pediatric health screenings and learned explanations and interpretations of test results. Their acquired knowledge led them to realize that early medical screenings and routine primary care led to diagnosis of any disorder.

Furthermore, they discovered that a positive rapport could be established with the medical professionals in their children's health care programs. By learning through the workshops how to interact appropriately with the medical staff, they established a better relationship with them. Their kept appointments enabled the parents to receive service at the scheduled time, gave clinic staff more time to explain, and eased the feeling of being rushed for both parents and the clinic personnel.

The data provided support for three central propositions: (a) Parents need to be taught about pediatric preventive and curative health concepts and then be given the opportunity to assume responsibility for carrying out those practices; (b) they often lacked knowledge of effective well-child practices, which is probably related to their own childhood lifestyles; and (c) disadvantaged parents have an uneasy attitude toward clinical professionals. Some of the barriers are cultural, economic, and educational differences, which underscores the challenging and emotional relationship between parents and professionals.

Four parents missed appointments. Upon investigation (as advocated by Friman et al., 1985), it was found that they all had valid justification: in one case there had been a death in the family; in the second, another child was sick; in a third, the mother herself was ill. The fourth parent simply forgot under the pressure of other stated personal concerns. But she made another appointment on her own, without prompting.

The pre- and post-test results revealed a wealth of valuable information. The three workshops, the pre- and post-tests given to parents, and the conferences and the telephone calls revealed how parents perceived themselves in relation to health professionals and their uneasy relationship with those professionals. Many viewed

themselves and their children as vulnerable. Others stoically reported seeing themselves and their children as caught on the low end of the natural imbalance between the "helper" and "helpless," the "powerful" and "powerless," the "expert" and the "nobody." These negative images seemed to be very deep-seated. Furthermore, the participants indicated that it was particularly difficult to function productively in a relationship where authentic empathy is felt to be absent.

The practicum combined elements that had been utilized in previous studies that sought to educate parents to assume responsibility for their children's medical appointments. Both Banta et al. (1979) and Bryant (1986) conducted training sessions, with medical and professional staff working in collaboration with parents. Richardson (1987) emphasized that educational strategies should be integrated into primary well-child visits. As in the study of Friman et al. (1985), parents were reminded the day before of their appointments in person or by telephone, and carfare or transportation to the clinics was provided if needed. The Virginia State Division for Children (1981) focused on health screenings, treatments, and immunizations, since (as this writer can attest from her own experience) many parents are unaware of which immunizations their child received during a routine health visit. All these strategies led to increased parental responsibility for keeping their

children's well-care appointments. The writer's results verified the success of these studies.

They also confirmed Polnay's (1984) conclusions that families whose lifestyles are respected and whose needs are met become involved in their families' health practices. Low income parents who are provided with opportunities to acquire effective parenting skills and medical concepts learn to become independent. They acquire the knowledge to improve their circumstances and to influence local educational and health institutions to be more responsive to their needs and those of their children. They are not intimidated by educators and other professionals.

The writer encountered many depressing incidents. Many parents realized the degree to which their children had been deprived of prescribed follow-up care. One parent tearfully told of how her asthmatic 4-year-old had been blamed for keeping other family members awake at night. She had neglected to keep the child's return clinical appointment and to keep prescriptions filled because she saw the child's behavior as "spoiled" and seeking "attention." Several times the child was taken to the doctor during a medical crisis and was placed directly in therapy. The mother assured the writer that she would keep all future scheduled clinic appointments. Another mother had been informed that her child had six dental caries and needed "restoration" care, but her mother had convinced her that baby teeth were

"not important" and would fall out. Consequently, no follow-up was done until the child had become unable to eat, had lost weight, and had toothaches which led to gum and mouth infection. When the child was taken in for emergency medical care, he was hospitalized for 2 weeks.

In another instance, a 4-year-old boy had sustained a severe eye injury several months prior to his enrollment in the writer's program, and had received only emergency care. The writer intervened for follow-up care. The consequences of the parent's failure to keep scheduled appointments were loss of the child's eye, surgery, pain, separation from parents due to hospitalization, and an artificial eye. The mother became distraught, blaming herself for not being responsible for her child's welfare. The writer had to refer the mother for a psychological evaluation and possible therapy to help work through her guilt.

Polnay (1984) believed that many parents had been exposed to a disadvantaged childhood and were unable to pass on to their children that which they themselves had not received. He reported that many inner city parents went from a deprived childhood to a deprived adulthood during their teenage years. Thus, they became immature "adults," whose own needs were so great they superseded those of their children.

The writer realizes that these results are unusual. They can be attributed to comprehensive efforts. Initially,

at the beginning of the practicum, the writer conferred with four directors of inner city clinics, and the medical staff who provided health care to children had been made aware of the parents' negative feelings. The center staff was thoroughly briefed in advance and went to extraordinary measures to keep parents in the program. When necessary, they telephoned or made home visits. Each workshop was well publicized in advance with posters. Communication among center and clinical staff and parents was highly organized. Transportation by agency vans or carfare for public transportation was made available if needed. Hot meals at odd times were provided for children who had missed them because of clinic appointments. The writer believes that the exceptional success of this practicum was possible only because of these supportive measures.

At the conclusion of the practicum, the 100 parents evaluated the overall effectiveness of the 12-week program in light of the content, materials, knowledge gained, and the writer's style of presentation. They were asked to fill out a written evaluation form of nine questions, and indicate a choice of "good," "average," or "poor" (see Appendix L).

In summary, a 12-week practicum was designed and implemented to provide a comprehensive pediatric program for inner city parents. The rationale was to impart to parents their own role in their children's medical needs. The

writer provided three workshops in child health care, one-on-one conferences, and other support services. The workshops focused on the immunizations, screenings, results, follow-up treatment that their children were receiving at the clinics, and the health implications when parents are negligent.

The practicum also focused on the alleviation of parents' uneasiness toward medical providers. The intent was to help parents establish a rapport with their child's medical team and improve scheduled well-child appointments. The results of the program showed improvement in parental involvement. The children's health records reported all required medical screenings and results. Ninety-six parents out of 100 kept all scheduled clinic appointments. An overall positive change was noted in the parents' and the providers' attitudes. In essence, this practicum and its positive outcomes, based on the data presented, indicated that underprivileged parents can be taught to assume responsibility for their children's health care.

During the 12-week implementation, two unanticipated events enhanced the practicum. Four weeks after the implementation period began, 17 parents were hired to work as part-time dietician assistants after an allocation of funds that resulted from a proposal written by the writer and others during the summer. They worked 4 hours a day,

4 days a week. As a result of the required orientation and ongoing in-services, they rapidly grasped concepts about the medical and nutritional needs and disorders in young children. The writer provided the opportunity for them to share their acquired knowledge in the workshops and to be models to other parents. These dietician aides provided a positive image to the 100 other parents who participated in the 12-week practicum.

A second unanticipated event during the practicum turned out to be equally fruitful. Two pediatric residents from one of the four large inner city clinics volunteered to spend 2 half-days a week for 2 months at each preschool site, to interact with "normal healthy" children and with parents and staff. Their presence allowed poverty children to relate to medical professionals in a non-threatening environment. The medical professionals provided mini-workshops, conferences, and short consultations with parents on children's health habits and the medical services. The doctors' personal involvement with the parents supplemented and reinforced the writer's training and educational programs for the participants.

Another unanticipated factor was that three workshops were insufficient for the volume of information to be covered. Although the writer frequently emphasized the salient points, one or two additional workshops would have allowed more time for the students to digest the information.

Recommendations

The writer has four specific recommendations based on the results of this practicum. First, preschool nurses and health specialists should continue to plan and conduct educational pediatric health programs for disadvantaged parents. Second, public education should be designed to stress parental responsibility for well-child comprehensive care. Third, major efforts should be developed to provide and coordinate free transportation to parents who are using health facilities and have other young children. Fourth, doctors and other medical professionals should make it a practice to explain all screening results, diagnoses, and follow-up treatment procedures in simple terms based on the population's academic level.

Dissemination

The results of this practicum were disseminated in part in several ways. First, it was shared with the total staff through an in-service training program. Second, the writer implemented many of the strategies used in this practicum in 16 of the agency's preschool centers. Third, the results of this practicum have been disseminated to other health specialists throughout the inner city preschool program. Fourth, the information from the practicum was shared with members of the agency's Health Advisory Committee. On this

committee, many of the members are medical providers who are employed in urban health facilities. Fifth, and finally, the results of this practicum will be shared at a state and national preschool conference.

REFERENCES

Ames, B. H. (1981). Alabama children: A matter of commitment and priority. Special report to Governor Fob Jamos and the Alabama legislature. Vol. 1 & 2. (ERIC Document Reproduction Service No. ED 253 301)

Backett, M., Melouis, A., & Barvazion, P. (1984). The risk approach in health care: With special reference to maternal and child health, including family planning. Public health papers No. 76. (Report No. ISBN-92-4-130076-0). Geneva, Switzerland: World Health Organization. (ERIC Document Reproduction Service No. ED 254 304)

Banta, T. W., Higginbotham L., & Levin, M. (1979). Evaluation of East Tennessee's child health and development project. Paper presented at the annual meeting of the American Educational Research Association, San Francisco, CA. (ERIC Document Reproduction Service No. ED 176 882)

Bryant, G. (1986). Preventive health care for preschool children or health surveillance. Heath Park, Cardiff, Wales: Department of child health, University of Wales College of Medicine. pp. 195-205.

Cleveland Public Library, 325 Superior Avenue NE, Cleveland, OH. Telephone reference.

Durand, B. (1979). Unmet health needs of children and youth. American Journal of Maternal and Child Nursing, 4, 345-352.

Friman, P. C., Finney, J., Rapoff, M. A., & Christophersen, E. R. (1985). Improving pediatric appointment keeping with reminders and reduced response requirement. Journal of Applied Behavior Analysis, 18, 315-321.

Grant, J. P. (1982). The State of the World's Children. New York: United Nations Children's Fund. (ERIC Document Reproduction Service No. Ed 283 612)

Henry, S. A. (1981). Current dimensions of parent training. School Psychology Review, 10(1), 4-13.

Joint Economic Committee (1983). The effect of federal child and maternal health programs: Hearing before the subcommittee on economic goals and intergovernmental policy of the joint economic Congress of the United States, 98th Congress, first session. (Report No. H-rg-98-728) Washington, DC.

Malinoski, A., & Gressman, J. W. (1986). Integrating a family planning program with a county health department based maternal and child health program. Paper presented at the annual meeting of the American Public Health Association, Las Vegas, NV. (ERIC Document Reproduction Service No. ED 281 618)

National Center for Clinical Infant Programs (1986). Infants can't wait: The number. Washington, DC: Office of Education Research and Improvement. (ERIC Document Reproduction Service No. ED 278 477)

National Institute of Education (1985). Opportunity for success: Cost effective programs for children. A staff report of the selected committee on children, youth and families ninety-ninth Congress 1st session. Washington, DC: US Government Printing Office.

Nauta, M., Brush, L., Johnson, L., Affholter, D., Hewett, K., With Algere, L., Connell, D., Ladner, R., & Stepto, J. (1980). Evaluation of the child and family resource program (CFRP). Phase II Report. Vol.1: Research Report (Contract No.: HEW No. 105-79-1301). US Department of Education, National Institute of Education, Educational Resources Information. Cambridge, MA. (ERIC Document Reproduction Service No. ED 224 4614)

O'Brian, M. A., & Obrzut, J. E. (1986). Attention deficit disorder with hyperactivity: A review and implications for the classroom. Journal of Special Education, 20, 281-297.

Office for Maternal and Child Health Services (1986). Healthy mothers, healthy babies; A compendium of program ideas for servicing low-income women (Report No. DHHS-PUB-PHS-86-50209). Washington, DC: U. S. Government Printing Office.

Paget, K. K., & Nagle, R. J. (1986). A conceptual model of preschool assessment. School Psychology Review, 15(2), 154-165.

Polnay, L. (1984). The community paediatric team--an approach to child health services in a deprived inner city area. In J. A. MacFarlone (Ed.) Progress in Child Health. Edinburgh: Churchill Livingstone. pp. 187-198.

Richardson, S. F. (1987). Child health practices reported by day care center parents: Implications for early childhood educators. Paper presented at the Association for Childhood Education International Study Conference, Omaha, NE. (ERIC Document Reproduction Service No. ED 286 600)

Tinsley, B. J. (1987). The effect of maternal health beliefs on utilization of childhood preventive health services and child health. Paper presented at the Biennial Meeting of the Society for Research in Child Development, Baltimore, MD. (ERIC Document Reproduction Service No. ED 281 618)

Virginia State Division for Children (1981). Child health care: An investment in the future. Richmond, VA. (ERIC Document Reproduction Service No. ED 224 552)

APPENDIX A

CONTRACT FOR DENTAL SERVICES

CONTRACT FOR DENTAL SERVICE FOR ..... STUDENTS

This is an agreement between _____ (the
(Service Provider)
"Contractor") and the _____ (the "Agency")
(Delegate Agency)
for dental services to be provided to students enrolled in the ..... program.

1. Scope of Services

The contractor agrees to provide the following dental services to all ..... students referred by the Agency:

(a) Complete dental examinations to all children referred to Contractor's treatment facility, provided that each child is accompanied by a parent, legal guardian, or center staff. Complete dental examinations shall consist of an oral examination, diagnostic x-rays (where indicated), oral prophylaxis and topical fluoride treatment (where indicated).

(b) Dental care on a follow-up basis will be provided by the Contractor or on a referral basis, adhering to the wishes of the parents. Follow-up care will consist of restorative dentistry (as indicated), and dental health education. Completion of pediatric dental care shall be emphasized to all parents, legal guardians, pediatric patients and program participants.

(c) Coverage for dental emergencies during school hours.

All dental services shall be provided in accordance with Ohio Revised Code Section 4715.30 (A) and the ..... Performance Standards issued by the United States Department of Health and Human Services [see 45 C.F.R. Part 1304], which shall be deemed to be incorporated in this contract.

2. Compensation

(a) Prioritization for payment:

(i) For those children who are covered by Medicaid or another assistance program, the Contractor shall bill the State of Ohio or the appropriate agency for services rendered.

(ii) Children covered by insurance that provides dental benefits shall be afforded dental care by the Contractor upon submission of the necessary information by the parent to enable the Contractor to make application and/or prepare a statement for presentation to the appropriate insurance company.

(iii) Services for those children who are not covered by Medicaid, another assistance program or private insurance will be billed to the Agency.

(iv) Fees for specialized appliances will be paid after submission and prior approval of the

treatment plan and established needs of the patient. Treatment plans are to be submitted to the Council for Economic Opportunities in Greater Cleveland ("GEOGC") - ..... Dental Consultant.

(b) Fees:

A fee schedule is attached to the contract as Attachment A and shall be deemed to be incorporated in this contract. An itemized statement will be submitted for each student whose fees are paid by the Agency.

3. Medical histories; records.

The Agency will provide a complete medical history for each patient and a signed parental consent form for dental treatment. The Contractor will complete the ..... dental health records, including a description of treatment rendered and/or recommended, and fees charged at the time services are provided.

4. Training; education.

As requested by the Agency's Health specialist, the Contractor shall provide reasonable inservice training for staff and reasonable educational opportunities for parents.

5. Term.

This contract will be in effect from September 8, 1987 (commencement date) until July 30, 1988 (contract completion date).

6. Termination.

This contract can be terminated by either party upon not less than 30 days advance written notice. In addition it may be terminated by either party at any time for cause, upon written notice to the other party. In the case of the Contractor, cause shall include, but shall not be limited to, the commencement of any disciplinary action under the Ohio Revised Code against the Contractor, any principal or partner of the Contractor, and/or their agents.

7. Independent Contractor: Insurance.

The Contractor shall be an independent contractor and not an employee of the Agency and shall maintain a policy of liability insurance in the minimum amount of $200,000 to cover any claims arising out of the performance of services under his agreement and shall further indemnify, save harmless, and defend the Agency from any claims arising from any act or omission of the Contractor or the Contractor's agents.

8. Availability of Fiscal Records.

The Contractor shall prepare for and cooperate with examiners of GEOGC, the United States Department of Health and Human Services (HHS) and the Agency and shall make all fiscal records available for inspection at any time by authorized audit personnel of GEOGC, HHS, and the Agency.

In addition, the Contractor shall make appropriate books, documents, papers, and records relating to expenditure

of HHS funds available to the Secretary of HHS, the Comptroller General of the United States, GEOGC, the Agency or any of their duly authorized representatives, for examination or copying upon reasonalbe request.

9. Discrimination.

No person shall on the ground of race, color, national origin, or sex be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available under this contract. Any prohibition against discrimination on the basis of age under the Age Discrimination Act of 1975 or with respect to an otherwise qualified handicapped individual as provided in Section 504 of the Rehabilitation Act of 1973 shall also apply to any such programs or activity.

10. Assignment.

Neither this agreement nor any duties or obligations hereunder shall be assignable by the Contractor without the prior written consent of the Agency. In the event of an assignment by the Contractor to which the Agency has consented, the assignee or legal representative shall agree in writing with the Agency to personally assume, perform, and be bound by the convenants, obligations, and agreements contained herein.

11. Successors and Assigns.

Subject to the provision regarding assignment, this agreement shall be binding on the heirs, executors, administrators, legal representatives, successors, and assigns of the respective parties.

12. Entire Agreement.

This agreement supersedes any and all other agreements, either oral or in writing, between the parties hereto with respect to the subject matter hereof, and no other agreement, statement, or promise relating to the subject matter of this agreement that is not contained herein shall be valid or binding.

WITNESSES: AGENCY: _____

_____ _____

_____ BY: _____, Title _____

Date: _____

CONTRACTOR: _____

_____ _____

_____ BY: _____, Title _____

Date _____

PROVIDER: _____

DATE: _____

ATTACHMENT A -- FEE SCHEDULE

1) Complete dental exam to include medical history, clinical oral examination, diagnosis, complete oral x-ray as needed, prophylaxis and topical fluoride application, charting of oral conditions $17.00.

2) Restorations

a) Amalgam	
one surface	$12.00
two surfaces	$15.00
three surfaces	$17.00
b) Composite	
one surface	$12.00
two surfaces	$15.00
three surfaces	$17.00
3) Extractions	$10.00
4) Stainless Steel Crown	$20.00
5) Pulpotomy	$20.00

NOTE: The cost of additional services shall not exceed the rate provided under the Medicaid Reimbursement Schedule.

APPENDIX B

WRITTEN LETTERS FROM STAFF AND PROVIDER

May, 1988

Memo - Health Specialist
from - Parent Counselor
Dental Follow-up

4/26/88

Ms. Hunt had three appointments with Rainbow's, they called and cancelled her appointment. I (I. Smith) gave her Dr. Robinson's telephone number to make an appointment and get the caries filled. They will call back.

Mar. 28, 1988

To Whom It May Concern.

To confirm Mrs. Sarah Mack statement.

We have had a number of children which the parents did not keep their follow-up appointment due to one reason or another. However, for these children to remain in the ..... program, the staff had to intercede, and take these children for their follow up treatments through service provided by the ..... program.

Rec. Teacher
3/28/88

March 11, 1988

To Whom It May Concern:

As a colleague of S. Mack, I share her concerns. She has the 2nd largest child care program in the city. Getting many to be involved in their children's preventive and follow up treatment(s). I am experiencing the same deficits in my program. This area is the focus of attention, because it is the children who are loosers.

Health Specialist

Anita, R.N.

March 31, 1988

Over the years as being employed as a Health Coordinator, one of the repetitive major problems viewed are non-compliance of medical follow-up. At the delegate level all interventions are implemented according to our program objectives.

Initial screenings for physical assessment are completed prior to entry, dental screenings are done during enrollment. Children indicative of follow-up are provided with resources of available providers; and the parents are also provided transportation if no other means available.

Parents are trained regarding the health needs of their children, and the reasons for follow-up care. Allotted time is always extended but the parents appear to wait until the last minute, and the timeline is extended.

Although the majority of children enrolled meet the criteria for entrance into ....., the 100% percentage of follow-up is not met, due to poor parental compliance.

Our program has made some recommendations; thru in-service for staff on a complete physical and dental record. Also, meeting with parents at center meetings, informing them on what to expect from providers.

In view of the circumstances mentioned in my letter, I hope that you will consider our efforts to improve our overall monthly percentages in Health.

A. D. D.

Health Specialist

March 31, 1988

To Whom It May Concern:

I, a parent counselor, have found it hard to get parents to take children back for follow-up. I have had to have several conferences with parents and ask Mrs. Mack to conference the parents around the importance of follow-up. The parents feel like, because the baby teeth will fall out then their is no need to take them back. I have had to make the appointment and have the parents sign permission for me to take them to the dentist. Some parents say the child act up when they take them and the dentist will not do anything. Some parents are afraid of the dentist themselves, because after reminding the parents and calling the day of the appointment then some still don't go to the dentist. I have had to make another appointment after this then the child will go. I invite the parent to go to the dentist with us, so that they can see what the dentist will do. When some parents have to do follow-up on their own, they just don't go after I offer bus tickets for the trip.

Thank you

Parent Counselor

March 28, 1983

To Whom It May Concern:

To confirm Mrs. Sarah Mack's statement.

We have had a number of children which the parents did not keep their follow-up appointment due to one reason or another. However, for these children to remain in the ..... program, the staff had to intercede, and take these children for their follow-up treatments through service provided by ..... program.

April 26, 1988

Dear Ms. Mack,

As you know we have been servicing children from _____. Our screenings have been quite successful and we have managed to exam, clean, and give fluoride treatments to a majority of the children.

However our efforts to see the children needing further treatment has been a challenge. We have worked with the _____ Center leaders, provided taxi service to transport the children to the office and called and sent letters to the parents.

We would like very much to involve the parents more closely in this follow-up process, and encourage them to take more responsibility for their children's dental health. Please don't hesitate to call if you would like to discuss this matter.

Thank you,

APPENDIX C

PRE- AND POST-ATTITUDE TEST

QUESTIONNAIRE

PRE-/POST-ATTITUDE TEST

Please answer all questions: Always - Usually - Sometimes - Seldom or Never. The questions will be rated on the following keys:
Always = 5, Usually = 4, Sometimes = 3, Seldom = 2, Never = 1.

1. Do you keep all scheduled well-child appointments?

   Always___ Usually___ Sometimes___ Seldom___ Never___

2. If you are unable to keep your child's appointment, do you call to cancel or don't go?

   Always___ Usually___ Sometimes___ Seldom___ Never___

3. Does the doctor or the nurse explain all instructions so that you understand?

   Always___ Usually___ Sometimes___ Seldom___ Never___

4. Do you hesitate to ask questions when you do not understand?

   Always___ Usually___ Sometimes___ Seldom___ Never___

5. Is your child seen by the same doctor on each clinic visit?

   Always___ Usually___ Sometimes___ Seldom___ Never___

6. Do you feel the clinic staff talk down to you?

   Always___ Usually___ Sometimes___ Seldom___ Never___

7. Do you feel that you are rushed through your child's clinic visit?

   Always___ Usually___ Sometimes___ Seldom___ Never___

8. Do you feel that the doctor and nurses' attitudes, beliefs, and values keep you from using the well-child clinic?

   Always___ Usually___ Sometimes___ Seldom___ Never___

9. Do you have to wait for long periods at the clinic?

   Always___ Usually___ Sometimes___ Seldom___ Never___

10. If you had a choice, would you prefer to take your child to a private doctor or the clinic?

    Always___ Usually___ Sometimes___ Seldom___ Never___

APPENDIX D

LIST OF MEDICAL SCREENINGS IN ANNUAL PEDIATRIC EXAMINATION

EXPLANATION OF MEDICAL SCREENINGS AND RESULTS

FOLLOW-UP PROCEDURES

MEDICAL SCREENINGS THAT SHOULD BE INCLUDED

IN A ROUTINE PEDIATRIC EXAMINATION

Immunization Assessment

Dental Examination

Weight/Height Measurements

Hematocrit/Hemoglobin (Blood work)

Lead Test (Blood work)

Tuberculin Skin Test

Vision Screening

EXPLANATION AND INTERPRETATION OF MEDICAL SCREENINGS AND RESULTS

1. Hematocrit/hemoglobin--a screening to determine anemia condition. There is less than normal numbers of red cells in the body's circulation system. The red blood cells carry the oxygen to all parts of the body. A child is considered anemic if his or her hematocrit is 34 or below, or if the hemoglobin is 11 or lower.
2. Tuberculosis (T.B. tine test)--is a prick on the skin of the inner part of the child's forearm with a three-pronged small instrument. It is read within 48 to 72 hours. It tests whether the child has been exposed to TB germs.
3. Vision--a test for vision problems. It determines the child's ability to see near and far objects clearly. Some eye problems can be treated if detected early; if delayed until the child is much older, it can result in permanent damage.
4. Lead test--is given to determine the lead level in the blood. Untreated high lead levels result in brain damage and learning disability.

5. Weight/height--is taken to determine whether a child is growing appropriately according to age and to check for any posture change. The weight is to be taken while the child is undressed. The height is to be measured without shoes.
6. Dental screening--an examination of the mouth and teeth which checks color and condition of "baby" teeth. The teeth should be cleaned with an application of fluoride to prevent tooth decay. If good dental hygiene is practiced, the child's permanent teeth will be sound and strong, and healthy. Dental care requires proper diet, not junk food, daily brushing and regular visits to the dentist.
7. Immunizations--are given for the prevention of infectious diseases in children. These vaccines are started during infancy and, with the exception of boosters, are completed during childhood. If these immunizations are omitted, children may be left crippled for life or brain damaged. Immunizations are for diphtheria, tetanus, and pertussis (DPT). These are combined vaccines known as three-in-one. The polio vaccine is the trivalent oral poliovirus vaccine, known as TOPV. Measles, mumps, and rubella vaccines also help to combat infection to the brain. They are given as a three-in-one shot at the age of 15 months.

FOLLOW-UP PROCEDURES FOR RECOMMENDED TREATMENT

HELPING CHILDREN TO GET WELL IS A PARTNERSHIP BETWEEN THE PARENT AND THE CHILD'S DOCTOR.

All scheduled follow-up treatment should be kept.

Interact with the doctor and learn about your child's diagnosis.

Have a clear understanding of what is expected of you as a parent.

Insist that the nurse or someone at the clinic write out all instructions for you.

Have the nurse write the date and time of the next scheduled appointment.

Write information on a calendar in a special place at home so that you do not forget appointment date.

Share information with preschool staff, so they can help you remember.

Know which doctor or clinical area you are to take your child to for treatment.

Report to the clinic at least 15 to 20 minutes before your appointment.

Keep a written report of how your child feels and acts between appointments; share this with the nurse and the doctor.

APPENDIX E

WRITTEN ACTIVITY - SCREENINGS REMEMBERED

Written Assignment

(2nd Workshop)

Write as many of the seven screenings as possible.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

APPENDIX F

ORAL ACTIVITY

INTERPRETATION AND MEDICAL RESULTS OF SCREENINGS

Oral Activity

Parents whispering to the writer, parent counselors, and medical assistants explanations and interpretations of screenings, and their results.

APPENDIX G

ATTENDANCE SIGN-IN SHEET

PARENTS: Attendance sheet

APPENDIX H

CENTER LOGS FOR MONITORING KEPT, BROKEN, AND CANCELLED APPOINTMENTS AND RECORDING UNANTICIPATED EVENTS

LOG FOR MEDICAL/DENTAL APPOINTMENTS AND FOLLOW-UP TREATMENT

child's name	referred where	age	TYPE OF APPT. Dental	Medical	Date of Appt.	Appt. Kept "K" yes/no	Unkept "UnK" yes/no	Appt. Rescheduled by parent	staff	Reasons for unkept appt.	Location of appt.	Details	FOLLOW-UP CHILD TAKEN BY staff	parent

Code:
Data for dental recorded in green.
Data for medical recorded in red.

CENTER LOG FOR ANY UNANTICIPATED EVENTS

Date of Event	Nature of Event	Persons Involved	Description of Event

APPENDIX I

MEMORANDUM TO DOCTORS

MEMORANDUM

Date:

To: Health Providers

From:Writer

Re: A complete routine pediatric physical examination.

_____ is seeking enrollment in our preschool for the school year of 1988-89. According to the preschool Performance Standards, all children ages 3 to 5 are required to have a comprehensive undressed physical examination that includes the following screenings and results to be reported on the child's health record:

Nutrition assessment (weight, height, hematocrit/hemoglobin values)

Vision

Tuberculin skin test

Lead level

Dental examination

Assessment of immunization status and completion of recommended immunizations.

The primary objective of these cursory screenings is to promote preventive health care and early intervention in young children.

Your immediate attention and response is greatly appreciated.

Thanks for your cooperation.

Sincerely,

.....

Agenda for Parent Meeting

Theme:

Making children healthy - Keeping children healthy.

Workshop 1

I. Healthy Children are Happy Children

A. Getting to know you and myself "ice breaker" get acquainted activity (10 minutes). Administration of pre-survey test (10 minutes).

B. Teamwork: "You, your child, and the doctor."
1. Know your child's health team.
2. How not to feel intimidated by the medical professionals.
3. Why keep scheduled medical appointments.

C. What constitutes a complete child's physical examination.
1. An undressed physical examination.
2. Examination of all body parts.
3. Nutrition and immunization assessment.

Health & Education
Workshop for Parents

Workshop #1

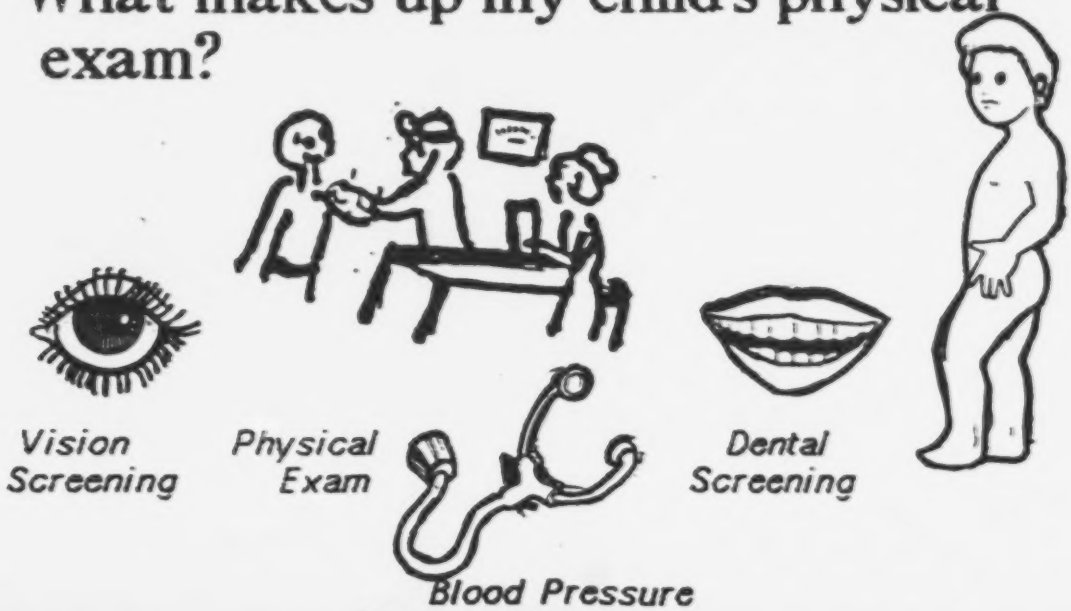
Come ... Come ... Come

Have Fun

Get Acquainted Activity

Ice Breaker
Parents & Doctors are Teamworkers
Why Keep Your Child's Appointment

What makes up my child's physical exam?



ICEBREAKER

An "icebreaker" was used in the workshops to promote an accepting, warm, and friendly atmosphere. Get-acquainted activities serve to help parents relax and become involved in the group.

Find persons who meet the qualifications listed below and have them sign their names.

1. Find someone who is wearing the same color clothes as you _____.
2. Find someone who has the same hair style as you _____.
3. Find someone who has the same number of children as you _____.
4. Find someone who has the same number of boys _____ or girls_____ as you.
5. Find someone who lives in the same area as you _____.
6. Find someone who plays the lottery or doesn't play the lottery, as you do _____.
7. Find someone who likes the same soaps as you do _____.
8. Find someone who likes to shop at the same department stores as you _____.
9. Find someone who takes their child to the same well-child clinic as you _____.
10. Find someone who likes to travel, as you do _____.

Agenda for Parent Meeting

Theme:

Making children healthy - Keeping children healthy.

Workshop 2

I. Don't Let the Bugs Bite: "Immunize Me."

A. Childhood communicable disease can be prevented or controlled.
   1. Signs and symptoms.
   2. Your role as a parent.

B. How to access community resources.
   1. Review and discussion of community resources that are available and affordable (review of the Pre-admission Parent booklet).
   2. Utilization of available resources.

Date:
Time:

Learn About
You and Your Child's Health

Workshop #2

Agenda for Parent Meeting

Theme:

Making children healthy - Keeping children healthy.

Workshop 3

I. Nutrition and Dental Health are "Twins".

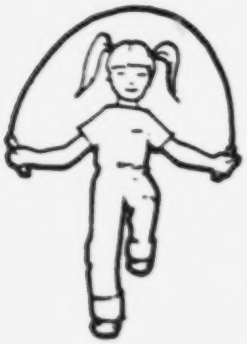
A. You are what you eat.
   1. Good nutrition
   2. Junk food
   3. Body and blood cells

B. The function of teeth.
   1. For chewing
   2. For talking
   3. For appearance

Healthy Children are Happy Children

Workshop #3

What is Good Health?



What is Good Nutrition?

Look!

I am OK

I am Happy

I am Helpful

APPENDIX K

DOCTORS' UNANTICIPATED WORKSHOP AND LETTER

!!! To Parents !!!

An Unplanned Workshop by Physicians

Surprise!

A Doctor Will Visit for 4 Hours

At Your Child's Center

When:
Time: 8:30 AM - 12:30 PM

Ask ? Get Answers

Ask ? ?

? **Get Answers**

Ms. Sarah Mack.

Dear Ms. Mack:

Thank you for the orientation to your agency for the residents. I am enclosing a list of date for Drs._____ and _____ to visit some of the sites.

Those sites not visited this time, may be visited by the residents on assignment next fall.

Again, I really appreciate your help and that of Ms. _____ in making this a good learning experience for the residents.

Sincerely,

Acting Director
Pediatric Inpatient Services

AFFILIATED WITH THE SCHOOL OF MEDICINE OF

APPENDIX L

EVALUATION OF PRACTICUM

PARTICIPANT EVALUATION FORM

Date _____

PLEASE RATE THE 12-WEEK PROGRAM AS GOOD___ AVERAGE___ POOR___.

CIRCLE THE MOST APPROPRIATE ANSWER.

1. The 12-week parental educational program was GOOD, AVERAGE, or POOR.
2. The writer's style of presentation was GOOD, AVERAGE, or POOR.
3. All handouts and other materials were GOOD, AVERAGE, or POOR.
4. How do you rate the three assignments? GOOD, AVERAGE, or POOR.
5. The time spent and information given by the doctors was GOOD, AVERAGE, or POOR.
6. The knowledge gained at these workshops was GOOD, AVERAGE, or POOR.
7. How would you rate this program in terms of holding your interest? GOOD, AVERAGE, or POOR.
8. How would you rate this program for other parents like you? GOOD, AVERAGE, or POOR.
9. The icebreaker activity was GOOD, AVERAGE, or POOR?

I thank you for the participation that you have demonstrated in the past 12 weeks.